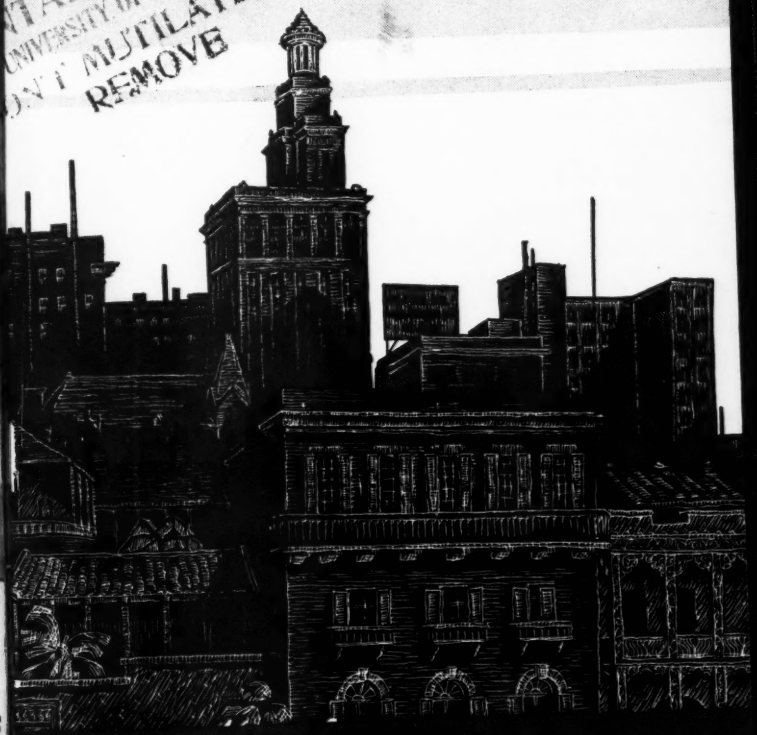

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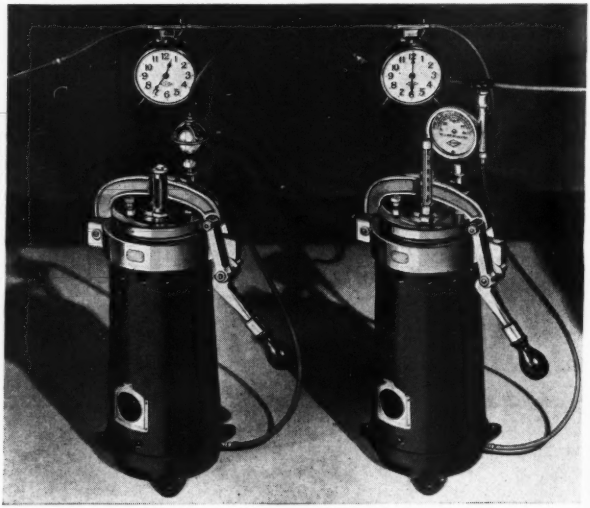

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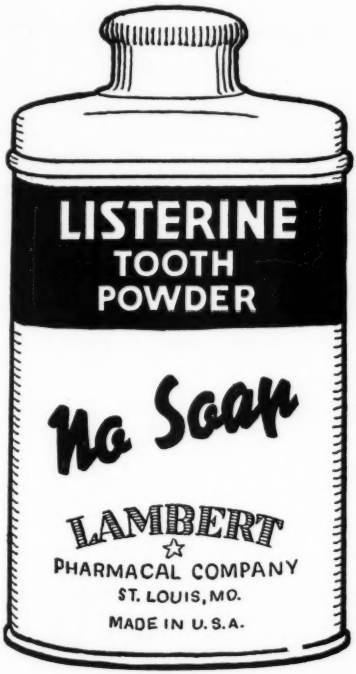
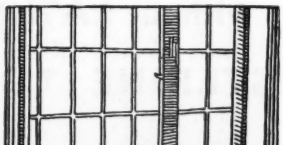


A Professional Size sample will gladly be sent to Dentists who request it on their letter head. Address: Lambert Pharmacal Company, Dental Dept., 2101 Locust St., St. Louis, Mo.

The Publisher's CORNER



By MASS

One wonders whether *The New Yorker* wants to get itself kept out of dentists' reception rooms so that patients will be forced to subscribe. Maybe that's it. Or perhaps it is because the magazine's famous Mr. Eustace Tilley has been getting his teeth fixed.

Anyway, for several weeks now *The New Yorker* has been strangely dental-conscious. It started with a not very funny cartoon in the May 11 issue showing a dentist picking the pockets of a gassed patient. "Now I'll extract a ten-spot in payment of his last bill," he is telling his assistant as he hands her the patient's watch.

Then, in the May 18 number, there was that full page burlesque of the "Ask ORAL HYGIENE" department. You may recall that here in the office we were confused about that article because some dentists wrote us that it was grand humor, and others said it was part of a plot to undermine dentistry and ORAL HYGIENE. Unaccustomed as we are to doing our own thinking, we just didn't know *what* to think.

In the June issues of *The New Yorker* there was nothing at all about dentistry. But now, in July, as this CORNER is written, Mr. Tilley and his big-town cut-ups are at it again. In one of the July issues Mr. Tilley's Mr. Steig goes dental by way of twisting the tails of the chiropractors; dentists ought to like that. The Steig cartoon shows a portly patient stretched face down on a chiropractor's table. The latter is thumbing the base of the patient's spine. "Which tooth did you say hurts you?" he is asking. I think this picture is funny as

hell, but may be obliged to change my mind after reading next week's mail; so I'm liking it with my fingers crossed.

And now here's another July *New Yorker*, the one for July 20. In this issue Mr. Tilley's Mr. Farbstein, in a piece entitled "Utilitarian Music" and subtitled "Some Novel but Practical Uses for Song," after describing how Doctor Edward Podolsky of Brooklyn employs Tschaikowsky's "Pathetique" to lower blood pressure, and the Toreador song from "Carmen" to raise it—how Herr Bruff of Oslo preserves food by drenching it with pipe organ music—how a Montana hospital brings patients out of anesthesia more quickly by playing "Sunny Side Up"—tells about Doctor Elmer Best, *Dental Survey's* editor, soothing patients by radio. "A recording and amplifying system, built into the operating chair, is used to maintain auditory contact with the patient's mastoid bone while the dentist is drilling." (Elmer described the device in *The Dental Digest* several months ago, you may remember.)

No dentist can complain about that item. It's a good "plug" for dentistry and jiggles no one's dignity.

But on another page of the same issue, the masthead page, Mr. Tilley—who seems to be a patient of Doctor Bissell B. Palmer—has quilled a paragraph complaining about the doctor:

"One of the discouraging things about literature as a profession is that it is not a profession at all and has no entrance requirements. To be a dentist, one must hold a degree from an academy; but to write a book, one need hold not so much as a bunch of violets. Anyone can join the ranks of us writers, leaving for the moment his own field—or sometimes not leaving it. There is a book out now, we notice, by Doctor Bissell B. Palmer, a surgeon dentist, who was last seen by us in an attitude of extreme extraction. He was using a chisel on us. As we lay there, gazing up into his eyes and wondering how long the novocaine would last, we never supposed that he was dreaming of a book. Which shows how little we know of what goes on in the heart of an extractionist!"

Yes, but what this department wants to know is: what goes on in the hearts of *New Yorker* editors and how do they get that way, and is it all part of a plot to abolish dentistry, or is it really a subtle build-up for a new stab at that battered project, dental education of the public?

Or is Dental Patient Tilley just getting even with Doctor Palmer?

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LEST you fall for the "come on" ballyhoo for so-called "all-purpose golds," let us remind you that, according to competent scientific authority, "there ain't no such animal." ¶ You can verify this statement by comparing the physical properties of these "all-purpose golds" — if you can get them — with the physical properties of golds which are scientifically prepared specifically for inlays and abutments OR clasps, bars, saddles, etc. ¶ The ideal strength, ductility, elasticity and hardness requirements vary too much for these structures to be embodied in any one alloy.

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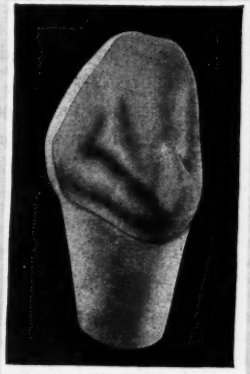

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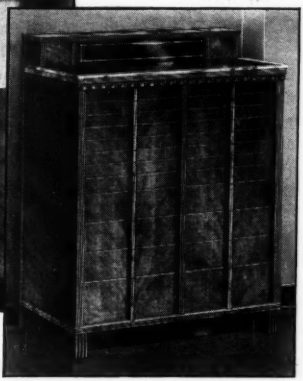

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If you haven't seen those two "Modern Americans," No. 140 (shown here) and No. 144, visit your dental supply dealer and inspect them personally. Also, send for the new American Catalog-Manual.

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FOOD IN THE OPEN CAN

● One question commonly asked concerning canned foods is whether or not the contents of the can should be removed to another container immediately after opening. This question has its origin in the belief that if food is allowed to remain in the can after opening, it will absorb an injurious substance from the can and thus become hazardous to the health of the consumer.

For this belief there is not the slightest foundation of fact. Its origin probably lies in the old "ptomaine" concept of food poisoning. Why it should persist in the light of present day knowledge is a mystery. The belief that food must be emptied immediately from the can has been as thoroughly discredited as the "ptomaine" theory of food poisoning (1).

Food poisoning is usually caused by the ingestion of food containing certain bacteria or their metabolic products. It is, in most instances, the direct result of improper preparation, handling, or storage of food (2) (3).

We have previously described in these pages how all canned foods are subjected to thorough heat treatment which destroys not only pathogenic bacteria and their products, but also the most resistant organisms which may cause spoilage. Consequently, the freshly opened can is the cleanest container in the average kitchen.

There is, therefore, no reason from the standpoint of food poisoning why the food must be removed immediately after the can is opened. In addition, food will spoil no faster or no slower in the open can than in any other open container. The same precautions should be used in its preservation as are used for any other cooked food.

With certain foods, it is desirable from the standpoint of quality to remove the food from the can. Such foods, usually those of an acidic nature, may act slowly on the can after air is admitted and small amounts of tin and iron may be absorbed. The traces of these metals have been shown by a Government laboratory to be entirely innocuous (3), but iron in particular may impart a slight taste to the food.

Modern science has dispelled the old belief that, from the standpoint of health, food must be removed immediately from the can. The cooperation of the medical profession in dispelling this old and unfair prejudice against their products is earnestly solicited by the members of the American canning industry.

(1) Journal American Medical Association, 90, 459, 1573 (1928)
(2) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century Co., N.Y. 5th Edition
(3) Food-Borne Infections and Intoxications, F. W. Tanner, Twin City Printing Co., Champaign, Ill.

This is the fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. What phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. Address a post card to the American Can Company, New York, N. Y.

CARIES IN CHILDREN

controllable but uncontrolled

Dental science and clinical experience have given us a method for checking the ravages of dental caries in children. This method is laborious and not ideally satisfactory, but when adequately applied it brings the incidence of this most widespread disease close to the zero point.

Extensive clinical data proves that caries can be held in check if these conditions are fulfilled:

1. *Professional care of pits, fissures, early decay and areas uncleansable by toothbrush and dentifrice.*
2. *Adequate nutrition, particularly with regard to minerals and vitamins.*
3. *Daily and thoroughgoing cleansing of the teeth.*

The cooperation of parent and child is required, in a program at home of scrupulous oral hygiene. One of the contributions of the program offered by the House of Squibb is a scientific dentifrice. That is to say, a dentifrice which is an effective cleansing agent, which will not injure teeth or gums, and which is safe for even the youngest children. Squibb Dental Cream is the result of many years of research to meet precisely these requirements.

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Vol. 25, No. 9 **September, 1935**

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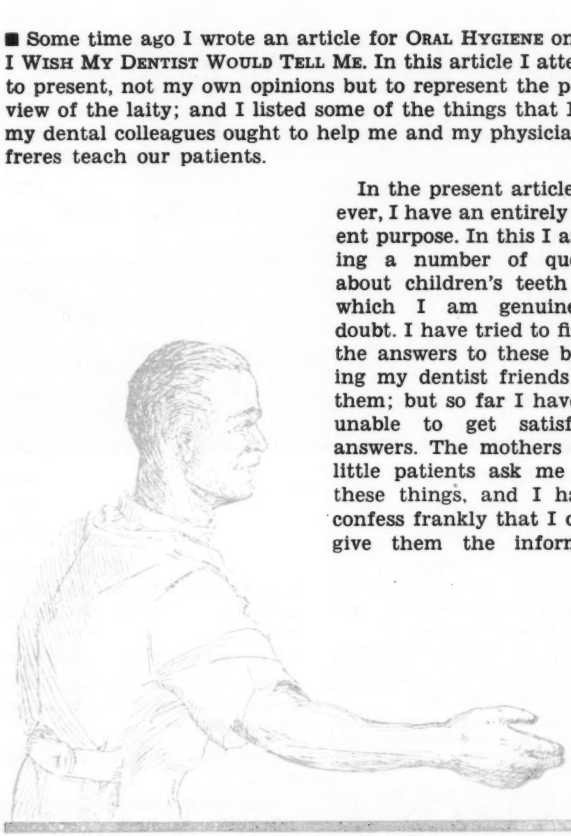
A PHYSICIAN ASKS

By FRANK H[illegible]DSC[illegible]

■ Some time ago I wrote an article for ORAL HYGIENE on WHAT I WISH MY DENTIST WOULD TELL ME. In this article I attempted to present, not my own opinions but to represent the point of view of the laity; and I listed some of the things that I think my dental colleagues ought to help me and my physician confreres teach our patients.

In the present article, however, I have an entirely different purpose. In this I am listing a number of questions about children's teeth about which I am genuinely in doubt. I have tried to find out the answers to these by asking my dentist friends about them; but so far I have been unable to get satisfactory answers. The mothers of my little patients ask me about these things, and I have to confess frankly that I cannot give them the information



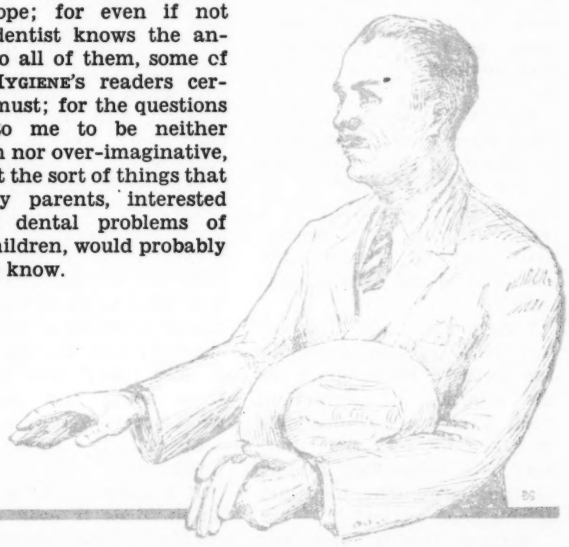
...OR DENTAL AID

...NK H...DSON, M.D.

they seek and are entitled to receive from me.

It occurs to me that some of these ought to be matters of common knowledge to the members of the dental profession. If so, then I have failed to make my meaning clear, when I have interrogated my dental colleagues —no other explanation is adequate. If not, then there is still hope; for even if not every dentist knows the answers to all of them, some of ORAL HYGIENE'S readers certainly must; for the questions seem to me to be neither freakish nor over-imaginative, but just the sort of things that ordinary parents, interested in the dental problems of their children, would probably wish to know.

I would certainly like to have some of you readers try answering these for me and my patients—and, by the same token, for the patients of all the rest of the pediatricians and general practitioners in these United States. The editor might like to open the col-



umns of ORAL HYGIENE to some of you who may care to help me. Somehow I don't believe I am more ignorant than the average physician—certainly not more so than the average layman—so if I don't know the answers to these questions, there must be many others who are just as much in the dark.

PUZZLING QUESTIONS

Here are some of these things that puzzle me and the mothers of my patients:

If deciduous teeth are not loose when the child is old enough to lose them, should they be extracted? If so, should they be taken out at once by the dentist; or should the child be encouraged to work at them and loosen them, as I have sometimes been advised to have children do?

Should deciduous teeth be filled when they are expected to remain in the mouth only a few months more? If so, should the restoration be a temporary one, or a permanent one? Of what nature should it be and of what material?

I have been told that before the extraction of deciduous teeth to make space for the eruption of permanent teeth, a roentgenogram should be taken for fear that there may be a congenital absence of the permanent toothbud. Is this good advice?

Suppose this is done, and the permanent toothbud is seen to be in its proper place; isn't there some danger that it will remain unerupted after the deciduous tooth is extracted? If not, why didn't it come down and cause the resorption of the root of the deciduous tooth at the proper time, if it is coming later?

Why do children in the same family, offered the same food, have such widely differing degrees of dental caries?

Do mouth washes prevent or retard decay? Is tooth paste necessary?

This whole question of orthodontia, its ethics and its mechanics, is as much a puzzle to the mothers of my patients as it is to me. We cannot understand why it should cost more than any other branch or specialty of medicine, surgery, or dentistry; or why when the physician, the surgeon, and the dentist do their work free in indigent cases when the patient needs it, the orthodontist apparently never does his without pretty steep remuneration. We are somewhat at a loss to find that the dental practitioner, who used to do minor orthodontic corrections before the specialty had the vogue that it does today, now shies off from doing any regulating whatsoever.

Specifically, these things puzzle us:

If a tooth erupts in malposition, does it ever regulate itself of its own accord? If so

when and why? If not, can anything be done by the patient to help? What?

I have been told at times by dentists that much could be done by a child, if he can be made to cooperate by pressing with tongue, fingers, or orange stick lever to make his teeth erupt correctly when they start to come in irregularly. Is this so; and if so, should it be done?

I was told the other day by a mother that she had heard of a new method of orthodontia without appliances. Is there such a method; and if so, what is the principle on which it is based?

Is there scientific proof for the statement that thumb-sucking changes the shape of the mouth and the character of the denture? How do adenoids affect development of the mouth and tooth structure?

What should be done in those cases, so commonly seen, in which the two upper central incisors are far apart? Do these ever come together as the child grows older? I have heard dentists advise cutting the labial frenum. Is this sound advice? If followed, how soon should results appear? Is the cure permanent?

Cost of Orthodontia

Coming back to the mystery of the high cost of orthodontia and the dental practitioner's apparent terror of treading upon the orthodontist's territory, I can understand how the complete operation of widening the jaw might easily be too complicated or involved for the practitioner in cases of marked crowding and bad closure. But why does the average dentist refuse to try to regulate a tooth when there is plenty of room to make the correction?

If the patient simply cannot, or will not, afford the complete job, why isn't "half a loaf better than no bread," in orthodontia as elsewhere? Why should a child be condemned to have a disfiguring dental deformity which is curable just because his parents and the dentist disagree over this matter of doing a "complete" job?

What is the right age for commencing orthodontic work? Some dentists tell us it should be begun in the early stages of the first dentition so as to correct rather than cure; while others say we must wait until the permanent teeth erupt in order that corrective work may be permanent? The latter doesn't seem nearly so sensible as the former; yet it seems to be much the commoner advice.

Is an amalgam restoration as permanent and as good, except for the cosmetic effect, as gold? How does gold compare with porcelain?

Would it be wise, if a patient could afford it, to have

roentgenograms taken of his teeth every few years beginning in earliest childhood?

What is the status of the devitalized tooth that is apparently giving no trouble, and from which its possessor is suffering no joint pains? Of the tooth that a roentgenogram shows to have "pockets." Of the tooth with "rarefied areas" at the end of its roots? Would a dentist with several teeth that fall into any of these three classifications be likely to have them all extracted as he so often urges his patients to do under similar circumstances?

What is meant by "acid mouth"? What is its cause? What is its cure?

What should be done for those little black specks that stain some children's teeth even though they are brushed faithfully?

How often should a dental prophylaxis be administered?

Perhaps all these seem "perfectly simple, my dear Watson," to my dental colleagues. To me, and to the mothers who ask me after asking their dentists and getting unsatisfactory or conflicting replies, they are rather upsetting. I am anxious to answer their questions; and having five youngsters of my own, of various ages, sexes, and degrees of dental development, I am anxious to know the answers in order to solve some of the questions that are constantly presenting themselves to their mother and to me.

I realize perfectly that some of these questions are probably quite debatable as are many of the moot points that divide my own branch of the profession into factions. What has bothered me has been my inability to get clear-cut personal opinions bearing on them, whether or not that opinion might be the consensus of dental opinion on the subject. Dentists are men who do a great deal of original work, and I believe that this entitles them to form and hold their own opinions irrespective of what the leaders in dentistry may decree.

In my own profession we have suffered much from an overdose of authoritarianism. By this I mean the tendency upon the part of physicians to want to be orthodox by following the latest published conclusions, whether or not their own personal clinical experience happens to tally with big fellows' conclusions. It is only as internal medicine and surgery get away from this slavish craving for authorities to back up their opinions and get more respect for their own experience that we shall move forward as we should and utilize the vast accumulated reservoirs of personal clinical judgment backed by personal results. We are lamentably slow about learning this lesson; but I hope we are beginning to get

it now, even if imperfectly.

I should like to see the dental fraternity take this lesson to heart, and form its own opinions, guided of course by the pronouncements of the dental pundits, but not shackled by them. I should like to see them feel free to teach their patients, in the light of their own clinical experience, the things that they believe those patients ought to know about their teeth.

And these questions that have puzzled me are, I firmly believe, among the things that could well form the basis of such teaching. Meanwhile, I wish somebody would tell me what he—an ordinary practicing dentist—believes about them. My patients and I are ready to learn!

The Children's Clinic
Black Mountain, North Carolina.

SEEK MISSING PITTSBURGH BOY

The readers of ORAL HYGIENE are asked to aid in locating Frank W. Courson, 17½, who disappeared from his home in Pittsburgh, March 9, 1933. He is 5 feet 6 inches in height; weighs 138 lbs.; has a light complexion; brown, wavy hair; and gray eyes.

Dental description: 1. Broken incisal proximal angle, upper right central. 2. Proximal porcelain restorations in upper anterior teeth.

Anyone having information about this boy is urged to communicate with his sister, Mrs. Muriel C. Smith, Wilkinsburg Station, Pittsburgh, Pennsylvania.

Voluntary vs. Compulsory

INSURANCE

By MICHAEL PEYSER, D.D.S.

■ The purpose of dentistry is to promote public health by an adequate scientific service, within the economic means of all the people and with economic equity to the members of the profession itself. Since this purpose has not yet been accomplished, and in view of the generally increased social consciousness, well organized propaganda to promote health insurance has been disseminated in this country for the past two years by societies formed for the advancement of social security.

It may now be stated with some assurance, as indicated by a recent survey, that the trend in the dental profession is toward health insurance. The failure of dentistry to serve its purpose is the failure of private practice as now constituted. The profession must serve its purpose if it is to survive. It is therefore natural that there should be a search for a new system, or a modification of the old one.

Well informed dentists realize that this search is not altogether altruistic, as they see ultimate disaster to the profession in the continuance of the present system. National social trends, as disclosed by recent occurrences, clearly indicate that a failure of the profession to provide a new system itself will surely result in a new system being forced upon it by the public.

What are the proposed ways out?

1. Mutualism (Voluntary Health Insurance).

2. Socialization (Compulsory Health Insurance).

3. State medicine (Tax Supported Health Service to all).

Voluntary health insurance is in harmony with American traditions and customs. Experience in European countries, however, shows that voluntary systems generally give way in the end to the compulsory systems. This fact should not influence us either in favor or against the voluntary system because the scope of dental service abroad is limited. We can say, with

safety, that the American people would rightfully demand more dentistry than is provided in foreign countries. Surely the profession itself would insist on *adequate service*—a vague term now, but one which must be clearly defined in the near future. An *adequate service* would cost more than is now generally spent by the public. Would the people volunteer to spend more under a voluntary system? I am of the opinion that they would not. The reasons for this are economic and psychologic in nature. In the first place, the present economic level of the great majority of the population is such that they cannot afford and do not receive adequate dental service. Secondly, because of the prevalence of clinics and because of the paternalistic trend of government, the individual has come to expect free or virtually free health service. The public is today, therefore, less willing to pay for adequate dental care than ever before.

Problem Affects All

The problem of adequate health service is purely a sociological one and affects everyone. As in all other common problems, the burden of solution theoretically rests on all, but in reality is shouldered by those who can best afford to carry it. The old principle of taxation rules: that is, the greatest burden should rest on those with the greatest ability to pay. The persons for whom health insurance holds out the greatest benefits, and for whom the sociologists are so solicitous are the 90 per cent whose yearly income in the prosperous year of 1928 was $2000.00 and under. It is now estimated that their yearly income today is $1000.00 and under. This great mass cannot and *will* not volunteer to pay for health insurance. They are passing through a depression in which they see the tremendous expenditures for relief resting on those who have the "ability to pay." If the time should come when they will be asked to join a voluntary health insurance system, they will demand financial help from the government and get it.

This will lead to the compulsory system, because the government cannot help one group of volunteers at the expense of those who do not volunteer. The government cannot favor one group more than another. It will follow naturally that everyone in a certain category, based on occupation and income, will be forced to *volunteer*. Then a system of federal aid to states, such as now exists, and as is proposed in the new social security legislation, will prevail.

The Federal Government

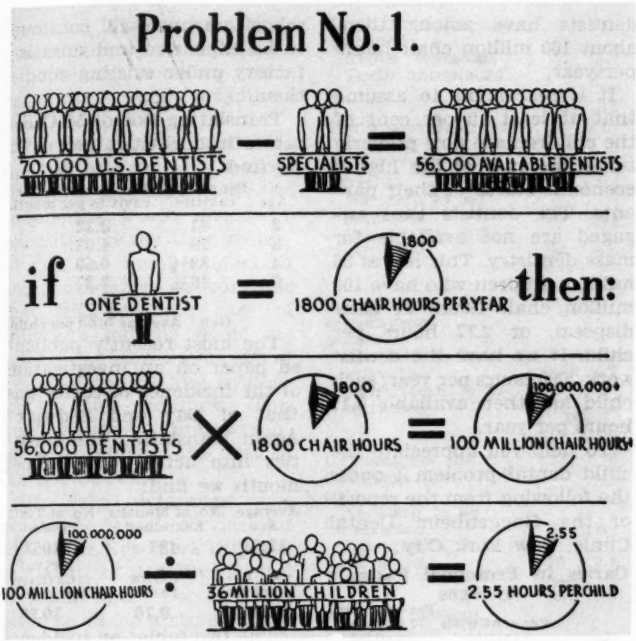
and the states will each contribute a certain percentage of the cost. The states in turn will then compel either the employer or the employee, or both, to contribute the rest. The Federal Government, in return for its contribution, will insist on certain minimum standards of service. This is one of the saving graces. And because of it, the compulsory system promises a better service. Because of federal and state support and the likelihood of employer contributions, the employee may get for his small contribution an adequate dental service. Under the voluntary system he could not possibly afford it and would not get it.

State medicine involves the complete change in our social, economic, and political order. The American people have to date evidenced no desire for any general upheaval. The result of such an upheaval is in the lap of the gods. If State medicine should be decreed, then the health professions will perforce have to acquiesce or face the firing squad.

ADEQUATE SERVICE

Having disposed of the systems through which an *adequate service* may be obtained for the masses, let us now measure the full length and breadth of the service required. As we begin to realize the potential dental needs of the public, we become aware that we are confronted with a problem of stupendous magnitude. If we are public health conscious and not so much concerned with immediate needs as with the full attainment of our ideals by a new system of "mass" dentistry, we must inevitably come to the conclusion that the foundation for the future lies in the children. This conclusion will gain greater force as the facts concerning an *adequate service* for all are revealed. The fulfillment of dentistry's purpose can be attained only through a system of prevention. Our present reparative system, devoted mainly to adults with the neglect of the children, remains our everlasting shame. We can never hope thus to catch up with and overtake the spread of dental disease. The dental profession now has no well defined system and is getting nowhere. We are like the frog in the well, climbing up two feet and falling back three.

A preventive system requires starting with children from the age of 2 up to, and including, 17. This includes over 40 million children. Prevention cannot be practiced on adults until and unless all the adults have previously had the benefit of prevention during childhood and adolescence. For the benefit of those who insist that to maintain industrial efficiency and national defense all the adults



"It has been ascertained that it takes three hours (average) per child for a complete operative dental service . . ."

must be properly served, with all the emphasis at my command, I say that this is at present an economic impossibility. The children must have priority for the present.

Let us consider the size of their problem. There are, at the most, 70,000 dentists in the United States. Twenty per cent of these, because of specialization, public health activities, or a well-to-do clientele, are not available for service, in any system of mass practice that will be necessary under any health insurance plan. This leaves approximately 56,000 available. Various estimates have been made of the number of chair hours per year available to the dentist. Bosworth, who had the most accurate data on this subject claimed that the dentist could work 1680 chair hours per year. Under a mass system I estimate the dentist could work 1800 chair hours per year. Therefore, the 56,000

dentists have among them about 100 million chair hours per year.

It is reasonable to assume that at least 10 per cent of the children are now properly served because of the higher economic status of their parents. The dentists thus engaged are not available for mass dentistry. This leaves 36 million children who have 100 million chair hours at their disposal, or 2.77 hours per child. If we have the dentist work 2000 hours per year, each child has then available 3.11 hours per year.

To help you appreciate the child dental problem I quote the following from the report[1] of the Guggenheim Dental Clinic, New York City:

Caries in Preschool Patients by Ages

Age	Per cent with cavities	Per cent with 7 or more cavities
2	47	13
3	79	37½
4	89½	56
5	96½	60

Doctor McCall observes further: "It has been found that preschool children with 7 or more cavities have an average of at least one tooth requiring extraction because of pulp involvement. The early and extensive incidence of caries in children below school age constitutes a distinct problem in community health . . . Obviously dental care instituted at the age of school entrance will continue to be expensive and unsatisfactory under existing conditions."

Translating Doctor McCall's tables into cavities per child we find:

Age	Per cent of cavities	Average number of cavities per mouth
2	47	2.32
3	79	4.98
4	89½	6.60
5	96½	7.27

Gen. Average 5.29 per child

The most recently published paper on an investigation of the incidence of caries was that of Day and Sedwick.[2] Again translating the statistics into actual cavities per mouth we find:

Average Age	No. of Mouths Examined	No. of Teeth Present
12.94	433	11058

No. of Cavities	Caries Index	Actual Cavities per mouth
7754	0.70	10.98

The two tables on incidence quoted here differ widely. Doctor McCall's figures were obtained from preschool children by dentists under his direct supervision and by a thorough, standardized technique. Day and Sedwick evidently were just as careful and thorough.

Speaking of the needs of New York City's school children, Doctor Harry Strusser has said: "It has been ascertained that it takes three hours (average) per child for a complete operative dental

[1]Salzmann, J. A.: Child Health Day. N.Y.J.D. 5:147 (May) 1935.

[2]Day, C. D. M. and Sedwick, H. J.: Studies on The Incidence of Dental Caries, Dental Cosmos 77:442 (May) 1935.

service . . . that it takes forty minutes to give each child instruction in brushing teeth, prophylaxis and examination."[3]

Taking either the McCall or the Day and Sedwick figures, or averaging both, and also considering Doctor Strusser's estimates on the time required and the number of chair hours available, we conclude that the adequate care of children's mouths would require the services of every available dentist and hygienist in this country. This would leave no dental personnel available for the rest of the population.

To help determine the needs of dental service for adults, the New York City Department of Health, Dental Division,[4] under Doctor Harry Strusser, made a study of the mouths of 1000 persons on relief. An analysis of the facts disclose the following:

Summary of Dental Findings
(In 1000 Patients in the White-Collar Class)[4]

	Cases No.	Teeth Aver.
Type of Case		
Decayed teeth	**889**	**4.8**
Teeth to be extracted:		
All teeth present	**46**	**2.5**
Some teeth previously extracted	**381**	**2.7**
	427	**2.6**
Teeth previously extracted:		
Teeth replaced		**2.0**
Teeth unreplaced		**4.3**
	863	**6.3**
Teeth previously extracted:		
A. No restorations present:		
No teeth to be extracted	**297**	**4.4**
Some teeth to be extracted	**260**	**5.5**
	557	**4.9**
B. Incomplete restorations present:		
No teeth to be extracted	**136**	**4.8**
Some teeth to be extracted	**101**	**3.6**
	237	**4.2**
C. Complete restorations present:		
No teeth to be extracted	**49**	**11.0**
Some teeth to be extracted	**20**	**9.1**
	69	**10.0**
All teeth present, none to be extracted	**91**	

Translating these tables into a simpler form we find:

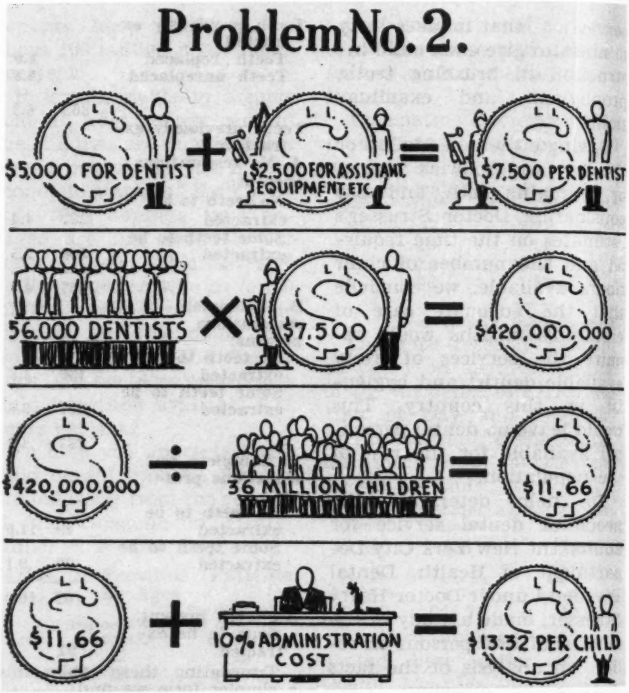
Number of Cases	**1000**
Average Cavities per mouth	**4.29**
Number of teeth missing per mouth	**5.45**

On the 1000 adult cases previously referred to, Doctor Alfred Walker estimated that it would cost $80.00 an average to restore those mouths, and these costs were based on extremely low clinic fees. There is no way to estimate the private average practice fee for those cases, but a safe guess would be be-

[3]Strusser, Harry: The Status of School Dental Clinics in New York City, In Correspondence Department, Dental Items of Interest 55:399 (May) 1933.

[4]The New York Tuberculosis and Health Association: Health Dentistry for the Community, University of Chicago Press. Page 38, 1935.

[4]Temporary Emergency Relief Administration Dental Clinic. New York City.



"If the parents would be forced to contribute one-half or $6.66, and the government the other half, the scheme becomes doubly plausible."

tween $125.00 and $160.00. How any insurance scheme could bear a 100 per cent incidence for service at a cost of $125.00 or more per insured is beyond human understanding. The wild talk of some health economists of $5.00 and $10.00 annual premiums for dental health insurance is too ridiculous to even merit discussion. Favoring the adults would be so costly as to be economically prohibitive and physically impossible because of the lack of dental man power.

The Chicago Dental Society in January, 1934, inaugurated the Industrial Diagnostic Service,[6] which offers free to

[6]The New York Tuberculosis and Health Association: Health Dentistry for the Community, University of Chicago Press, Page 39, 1935. Tylman, S. D.: Organization and Operation of the Industrial Diagnostic Service of the Chicago Dental Society, DENTAL DIGEST 40:226 (July); 40:272 (August) 1934.

employees "a complete dental health and diagnostic service." This service consists of an x-ray survey of 14 films, vitality tests, a clinical examination, advice and reference to private dentists.

In 2,720 employees examined the following was found:

Average cavity per mouth	2
Teeth previously extracted	5.8
Root ends, impactions	0.5
Per cent requiring restoration of missing teeth	82
Teeth requiring extraction per mouth	0.9
Teeth infected per mouth	0.4
Per cent requiring gum treatment	25
Per cent requiring full dentures	12

Thus we find that while the unemployed need a great deal of dentistry the employed need only slightly less. It can be readily seen that the present available dental man power would be utterly insufficient for performing the dental service required on our adult population of 90 million; of which approximately 6 million are in need of full denture service.

PREVENTIVE DENTISTRY

An analysis of available dental personnel when measured by the potential need for service required by both the child and adult population under any compulsory scheme for *adequate service* shows that we are numerically deficient. At the present time, under the private practice system, both classes are neglected—the children especially. Which class should we prefer? We must decide on one or the other. If I had my way, we would concentrate on the children. The children have everything before them; they are the hope of the America of the future.

The foregoing reasons for favoring the children fade into insignificance when we consider also that prevention must, of necessity, start with the child, and that a universal preventive system for children could be served by our available dentist man power within the economic reach of the nation.

Insurance for children is a more plausible possibility, despite the fact that no estimate of the cost for service for children in private practice has ever been made. If we take 56,000 dentists and allow them $7,500.00 a year for their services, including their office assistants, the use of their equipment and materials, this would leave them each $5,000.00 net. The total cost would be $420,000,000 or $11.66 for each of the 36 million children. Adding 10 per cent for administration the cost becomes $13.32 for each child.

If under a compulsory health insurance plan the parents would be forced to contribute one half, or $6.66, and the government the

other half, the scheme becomes doubly plausible; especially if the parents' share were spread over twelve monthly installments. The government in reality would not be actually spending $6.66 for each child, as it is claimed by Fones and Strusser, and others, that dental disease adds to the cost of child education because of absence and retardation. Who can deny that such an expenditure by the government for the children would yield 100 per cent dividends in a healthy population?

Dentistry for children should be compulsory as is education. To pay for it with tax funds places a greater burden on government and no responsibility on the parents. Besides tax supported child dental service would tend to destroy private practice, stimulate bureaucracy, encourage the politician's entry, and might result in a poor quality of service. The government has its stake in the children; so have the parents. Let them share the burden of the cost. Parents who are compelled to pay will demand and get good service.

Let us start a preventive system for children and do the best we can with the adults. All authorities agree that prevention must start at the age of 2, therefore, I suggest that it be made compulsory for parents to insure all children now at the ages of 2 to 8 inclusive, and after the inauguration of this plan, all children as they reach the age of 2—the insurance to continue until they graduate from high school. The necessity for adult service would, in time, be decreased drastically.

As for adults, there can be no compulsory system because of the tremendous cost and because of the physical inadequacies. So, the best that can be done is to provide a voluntary system for those who have the willingness and ability to pay. This means that a small percentage will be served but under a voluntary system the few may get an *adequate service* at a lower cost.

219 Jamaica Avenue
Queens Village
New York

LEACH CROSS

Prize Fighter and Dentist

By WALTER H. JACOBS, D.D.S.

■ That the dentist has done more than just promote dental health, and relieve suffering, has not always been recognized by a severely critical public. To many, the dentist remains a man apart; a person narrowed to a particular, delicate specialty, who has not been conceded much in the way of accomplishments beyond the limits of his professional work.

This unflattering opinion, however, does not persist when the facts are made known. A survey of the catalogue describing the "Exhibition of Historical and Scientific Dentistry, Creative Arts, and Varied Interests of Dentists," published for the New York Dental Centennial, December, 1934, shows in great detail the fields exclusive of dentistry in which our colleagues have engaged. Articles by Adair,[1] Weinberger,[2] and others, also discuss this most interesting subject.

In the lists we may find artists, musicians, inventors, authors, statesmen, naturalists—every conceivable vocation has been entered into, with success, by dentists. To all these pursuits, still another in which a dentist rose to considerable fame must be added; a spectacular, bruising profession that dates back to about 900 B. C., and is mentioned in the Iliad; that colorful profession demanding courage, strength, and skill —pugilism—and the dentist is Leach Cross!

Forty-nine years ago, Louis Wallach was born on New York's crowded, sweltering East side. His boyhood in this struggling maze of humanity was not, and could not, be easy. Everything to be gained, everything to be kept, had to be fought for; and only the strong in mind and body could advance. As an athlete

[1]Adair, R. B.: Contributions Dentists Have Made Outside Their Profession, J.A.D.A. 13:1359 (October) 1926.

[2]Weinberger, B. W.: Dentists Who have Distinguished Themselves or Rendered Services in Fields Other Than Their Profession, Polk's Dental Register, Page 71, 1925.

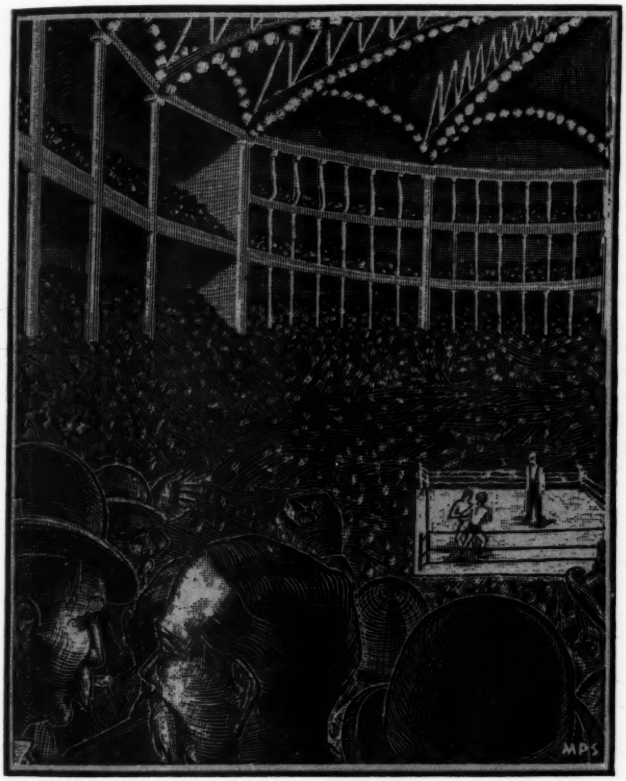
on the Clark House Settlement basketball and track teams he had gained considerable local prominence, not only for his ability in the sports, but particularly because he could lead the teams through the tough, hostile neighborhoods unharmed. He was recognized by his companions as their leader, their local chieftain, upon whom they might call for protection and support.

A strong heart, a sharp mind, flying fists, and success as an amateur, influenced the boy to become a professional boxer. He was quiet, modest, and had none of the offensive mannerisms so often associated with the pug. The next step was to change his name, for at this time in the history of the American prize-ring the field was dominated by the young Irish, and the man who was ambitious to get on adopted a Celtic *nom de guerre* to ease his way. Thus Louis Wallach became Leach Cross!

The fighters in those days lived high, wide, and handsome. "Live and be merry," was their creed: life was sweet to the young and strong; money came rolling in easily; and the adulation of the crowd turned the heads of these warriors from any serious thoughts as to their futures. But not Cross! He was determined to improve himself in every way possible. The money he earned with his fists he saved and invested; invested in something he knew was even more important and powerful than his physique—in his education! He paid for his way through high school, then for a short period at the College of the City of New York and finally he entered the New York College of Dentistry in 1904.

All through the period Cross was at school he supported himself by meeting the finest lightweights (133 pounds) of the day. In 1907 he graduated from dental school and he was now Doctor Leach Cross! He opened his first office at 320 East Third Street, New York City, and began to practice, but he did not give up the ring. During the day he worked at the chair and then trained in the gym or did road work at night so that he might be in excellent condition for his extra-professional career. Or perhaps he might have closed the office a little earlier on the day of an important bout so that his legs would stand up better during the fray.

Courage was a byword to Cross, and he must have had more than his share of it to stand up and fight against men of the caliber he did, and at the same time practice dentistry. It seems highly incredible! Cross fought Battling Nelson, "The Durable Dane;" Ad Wolgast, "The



"Madison Square Garden always echoed to the roars of an enthusiastic mob as Cross went into action."

Cadillac Bearcat;" Willie Ritchie, Freddie Welsh—four lightweight champions of the world! Names that go down in the annals of Fistiana make up his record—Jack Britton, Jim Driscoll, Joe Rivers, Charlie White, Packy McFarland, Joe Mandot—these are only a few of the top notchers this fighting dentist met. The shadows of Madison Square Garden always echoed to the roars of an enthusiastic mob as Cross went into action in bouts that made the old arena famous. North, South, East, and

West, Cross went to meet the finest men the promoters could obtain; and win, lose, or draw, in each fight he made ring history.

It was his practice, after a bout in which his opponent's teeth may have been injured, to offer his professional card. In this way he saw to it that he combined business with business. One of the most unique and interesting manuscripts concerning the ring belongs to Doctor Cross and is indeed highly prized by him: it is his diary of pugilism. Immediately after each fight he would write up the faults, idiosyncracies, and methods of his opponent, together with his own reactions as to the best manner to box this same fellow if they were ever to meet again. Too bad it has never been published; a more amusing and exciting document dealing with the subject has probably never appeared in print.

In the Spring of 1916, after a most successful career, leaving behind a record that will always be remembered, Cross retired from the arena to devote all of his time to dentistry. Soon he was seized with a desire to travel, and he headed for California where he erected and managed a beautiful apartment house in Hollywood, "The Cross Arms." Later he opened several restaurants, and he was in truth "on top of the world."

Then came the depression: many suffered; many lost; many quit. But not Cross! The fighting spirit and indomitable will that carried him on to his many ring victories served him well in a come-back more important than any encounter he had engaged in up to this time. Here his wise investment of many years before, his education, came to his assistance. Back into dentistry, with all his determination and courage went Leach Cross—and once more he scored a victory. He opened an office at 940 Fox Street, New York City, where he is practicing today. He is also an active member of the Allied Dental Society and the Bronx Dental Society.

When the last great history of our profession is written, and the tributes are awarded to those who have served, each in his own way, surely space must be made for one who has thrilled and entertained thousands; for a man who has shown others how to "come back"; for that slashing, dashing, modern swashbuckler—Doctor Leach Cross!

124 West Ninety-Third Street
New York, New York.

Doctor Konson
GIVES A CLINIC

By SETH W. SHIELDS, D.D.S.

■D. M. Konson, D.D.S., rose from his desk. He was completely surrounded by laboratory equipment. It might be said that any Hollywood producer who happened to glance into this particular den of science would immediately have become environmentally inspired to produce a picture combining and surpassing all the marvels of pseudo-science to be found in Doctor Jekyll and Mr. Hyde, Frankenstein and Dante's Inferno.

Doctor Konson walked to a sanitary, lift-top waste receptacle in a far corner of the room. In a technical manner employed by most dentists he placed his right foot on the lid lifter but he pressed it much more gently than do most of us. A sound not unlike the distant humming of bees greeted his efforts. Slowly the lid rose until the can was completely opened. As he withdrew a lozen shaped bottle containing an amber colored fluid from atop a bunch of soiled towels, a smile of satisfaction spread across his face. Any man clever enough to invent an electrically controlled waste receiver and professionally philanthropic enough to give it to the profession for the minor consideration of having his name stamped on each and every one sold and one-half the purchase price as a royalty

was "by gosh entitled to a drink and a smile of satisfaction."

D.M. (this affectionate appellation was used in addressing him by close friends) replaced the bottle and, by pressing another pedal closed the can. Returning to his desk he read for the fourth time a letter spread out flat before him:

April 5, 1935

D. M. Konson, D.D.S
703 East Thirty-third Street
Aesop, New York

Dear Doctor Konson:

It is with pleasure supreme that I take this opportunity of notifying you of your election to membership in the R.S.V.P. On behalf of the learned members of the Rural Stomatologic Vulcanite Prosthodontists I offer my sincere congratulations!

You will receive your mortar board and degree at our next convocation to be held at the same time our national dental meeting is held.

It will be necessary for you to present a scientific paper as a part of your initiatory program. May I be presumptious enough to suggest that you not only read a manuscript, but actually give us a practical demonstration on your recent marvelous contribution to our profession—the electrically controlled waste receptacle?

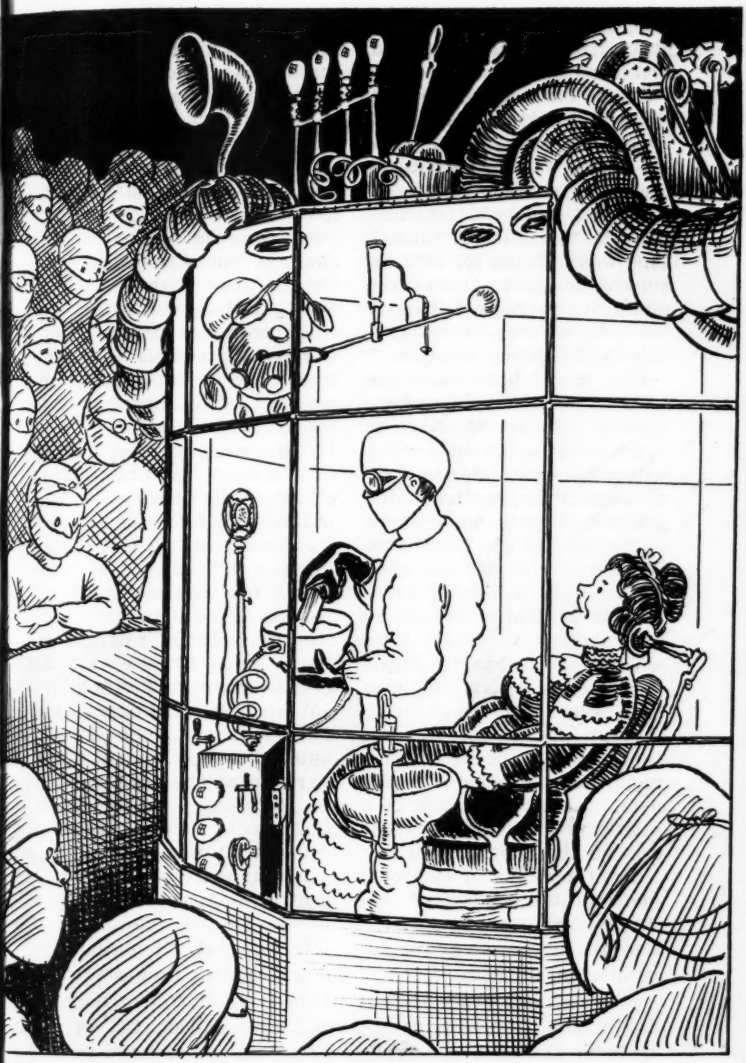
Thanking you kindly, I am,

J. D. Wise, Secretary.

R.S.V.P.

Except for a few minor details, dear reader, we will rapidly dash through the next several months until fall and the big event. Doctor Konson raised the nominal initiation fee required by the R.S.V.P. of $108.00 by securing a loan from one of the useful 3½ per cent a month loan companies. His ten thousand word article on THE STATUS OF THE WASTE RECEPTACLE TODAY required a considerable portion of his time. Patients were somewhat neglected, as were supply and laboratory bills. Little difference this made as he knew that fame and wealth were within his grasp as soon as the R.S.V.P. appeared after his D.D.S. How tragic that the seemingly unimportant financial facts about his brothers to be were not his! Little did he dream that even though a man usually earns money who marries for it, some R.S.V.P.'s actually had done such a thing. He didn't even imagine that a good old R.S.V.P.'er would permit patent medicines to be sold under his name and fatten his purse in that manner. Poor D. M.! What a mess he was getting into—what a mess!

The great moment finally arrived. In a ceremony as sacred to the society as to himself, the conferring of the degree was accomplished without a hitch. A fourteen minute burst of applause greeted his paper; and loud, sincere, and long were the technical discussions which followed it. It was a complete



...r mixing technique he employed the much used rotary motion interspersed with occasional criss cross and cement spatula methods."

symposium if ever one was given. It was a grand day and a gala occasion.

Home once more, Doctor Konson's pleasure was short lived. The first morning in the office two messengers presented checks, drawn by him, that had been returned marked, "Insufficient funds." This was difficult for D.M. to believe as seven checks remained in his book. A loan on the car, however, terminated this embarrassing situation.

Like his fellow man the taste of glorified achievement kindled the fires of scientific aggressiveness smouldering within his brain. During days he reluctantly continued his practice. Nights were spent in the laboratory. This nerve shattering routine was continued until a second great project of D.M.'s was ready for publication: THE CARE AND USE OF THE PLASTER BOWL.

For several years the idea had been slowly meandering through his mind. He was fully aware of the septic technique of impression taking necessitated by the lack of a satisfactory sterilization process for the bowl and spatula.

The processing of the spatula had been more or less simple. An antiseptic solution was all that was needed for immersion purposes.

But the bowl was a stumbling block: Certainly, it too could be sterilized by aseptic immersion, but the rubber of the bowl, being of a much less dense nature than the spatula, was more liable to scratches during the process of spatulation. These topographical indentations, in turn, would serve as strategic points for bacteria and their spores to hide and grow, and create a break in the aseptic chain he hoped to devise. But the sleepless nights, tedious work, and brain wrecking concentration were at last rewarded. An autoclave, which functioned by the remotest of remote controls, had been invented. The actual sterilization process was accomplished in a manner not unlike that employed by Pasteur in the pasteurization of milk.

Knowing the effect of high heat on soft rubber, or hard either for that matter, D.M. had perfected his machine to sterilize without ruining, as had Pasteur invented a process to make milk safe without spoiling. Cultures made from specimens of freshly autoclaved bowls had failed to reveal any bacterial growth in forty-eight hours. Again D.M. was to taste the saccharinized fruit of success.

His findings in detail were sent in manuscript form to a dental journal enjoying an international circulation. In a few months they were published, but horror of horrors: R.S.V.P. failed to appear after his, the author's name.

By return mail a letter was

dispatched to the editor calling his attenion to this colossal, almost insulting, error. The temerity of editors anyway, he mused, considering that microscopic minds were essential to becoming editors. Nor was he satisfied with the editor's answer which politely but plainly informed him that only earned degrees appeared after authors' names. The shock of this information and the inference that R.S.V.P. was not an earned degree sent him madly to the bottle of ease, still located in the receptable of fame, eight times in twice as many minutes!

It so happened that a medical friend of his, a nose, throat, and ear specialist, was located on the same floor. D.M. had on previous grave occasions such as this sought the surgeon's advice and now decided to do so again. Even a lawsuit was possible he thought!

In answer to his question about what drastic action should be taken, the kind old surgeon laid his hand affectionately on D.M.'s shoulder and softly said: "D.M., nothing can be done. *The Journal of the American Medical Association* publishes only earned degrees, too. Disgraceful—" and his voice trailed on through a mumbled, sorrowful sentence or two of consoling remarks.

Only the importance of a clinic engagement before the combined medical and dental societies of the city eased the wrath of D.M. Physicians and dentists were to see an impression taken of a living subject's mouth in a sterile manner.

Came the dawn or the night I mean. In the Dillinger room of one of the nicer hotels, a twelve by twelve room with glass walls had been erected. An assortment of devices resembling vacuum cleaner attachments surrounded the enclosure. Grouped about this automatically air-conditioned room were hundreds of physicians and dentists, all wearing sterile gowns and face masks. Even if the air was sterilized D.M. was taking no chances on a break in technique.

Donning his *sterile* gloves, gown, mask, shoe covers, and glasses handed him by a nurse, he mixed the *sterile* ingredients in the *sterile* plaster bowl with the *sterile spatula*. For mixing technique he employed the much used rotary motion interspersed with occasional crisscross and cement spatula methods. The impressions were taken; the applause that followed was deafening.

The room was conveniently equipped with a loud speaking system and, turning to his patient after order had been restored he said, "Mrs.

Jinkens, I thank you. I appreciate your time and believe my appreciation will manifest itself to you in the form of sterile dentures. And of what did the taste of the material remind you?"

"Chalk!" said Mrs. Jinkens.

Darlington, Indiana.

CONTRIBUTIONS TO A.D.A. RELIEF FUND INCREASE

The report for the year ending June 30, 1935, shows that contributions to the Dental Relief Fund of the American Dental Association from members totaled $15,574.97, according to Fred R. Adams, D.D.S., Secretary of the Fund. This represents an increase of $3,137.69 over last year's contributions, or a per capita increase of 5.28 cents per member.

In four states a smaller amount was donated this year than last. Colorado showed a decrease of $22.00; Connecticut, $2.60; Nevada, $1.50; and Vermont, $4.00. The District of Columbia gave $334.00 less this year; there was a decrease of 50 cents in Hawaii's contribution; and $6.00 less came from the Philippine Islands; while the United States Public Health Service had a decrease of $1.00 in donations.

Increases in the various states ranged from $1.10 for Arkansas to $554.45 for New York. Alabama dentists contributed $103.77 more this year than last; from Arizona $9.50 more was received; California State added $70.85 and Southern California's share of the increase was $62.20. Increases in other states were: Delaware, $90.00; Florida, $99.00; Georgia, $28.00; Idaho, $6.00; Illinois, $292.48; Indiana, $41.00; Iowa, $59.05; Kansas, $25.50; Kentucky, $43.51; Louisiana, $44.02; Maine, $12.00; Maryland, $87.50; Massachusetts, $54.30; Michigan, $141.60; Minnesota, $94.46; Mississippi, $1.50; Missouri, $69.90; Montana, $5.00; Nebraska, $64.40; New Hampshire, $9.50; New Jersey, $69.50; New Mexico, $12.00; North Carolina, $25.00; North Dakota, $13.05; Ohio, $312.25; Oklahoma, $23.50; Oregon, $48.55; Pennsylvania, $243.40; Rhode Island, $45.00; South Carolina, $14.00; South Dakota, $23.50; Tennessee, $96.50; Texas, $234.00; Utah, $78.00; Virginia, $20.50; Washington, $48.25; West Virginia, $25.50; Wisconsin, $69.35; Wyoming, $8.00. Puerto Rico added $7.00 to its contribution; the increase of the Army Dental Corps was $7.85; and of the Navy, $7.00, and the United States Veterans' Administration gave $5.00 more to the Fund this year than last.

Contributions from the dental trade and laboratories, exclusive of those donations that amounted to less than $5.00, totaled $1,246.00 for the year ending June 30, 1935.

EXTRACTION PSYCHOLOGY

By H. N. WORKHOVEN, D.D.S.

Noticeable confidence on the operator's part is perhaps the best means of quieting a nervous patient's fears . . . but the confidence must be genuine . . . ostentatious confidence is rather easily detected.

■ It is natural to admire the person who has such complete control of himself that he can do things that fear prevents the average person from doing. Because that quality is commendable and rare, admiration is due such a man. Almost as rare and just as commendable in the dentist's eyes is the person who can face an extraction without giving jittery evidence of considerable mental distress. He certainly deserves the title, "good patient."

Although his palms are clammy and his heart rattles nervously, he makes the best of his plight without any jerking, groaning, or acting to arouse sympathy. Some of these stalwart souls would stand an unanesthetized extraction without flinching. They are the four leaf clovers of mankind, at least to the dentists they encounter.

But these four leaf clovers of mankind are just about as rare as they are in a clover field. The mass of patients hamper the process of extraction, more or less, by twitchings, fainting spells, lip fighting, and even by bodily struggles. Of course, some of this wriggly group can never be made to cooperate, but the behavior of the others can certainly be improved to a point that will facilitate the

extraction considerably.

Before treatment of an unnatural condition the cause must be known. Elimination of the cause will cure the condition. To eliminate mental difficulties in extraction it is well to find and eliminate the basic trouble. Fear causes virtually all temperamental display on the patient's part. Of all fears, perhaps the greatest is fear of pain. The next fear likely to arise is one not so generally recognized: the patient is afraid of making a foolish spectacle of himself in the eyes of the dentist. The result of this fear may often cause a tremendous tension detrimental to operating if something is not done to allay it.

Still another fear is related to the extraction. A patient worries about the appearance of, or possible harm to, adjacent teeth. The uneducated may have weird fears, such as the danger of a child being marked when a pregnant woman has an extraction, complications of the eye following removal of the cuspid, or a similar superstition regarding the "stomach tooth."

Find Cause of Fear

To find the chief cause of fear in the patient at the beginning of the operation is usually easy. Often he will give a lead by asking, if there is much pain involved. If, however, the patient seems fearful and will not talk, a general statement that there may be a little discomfort, but that all possible care will be taken, may be enough to straighten him out considerably. At any rate this will open the subject and he will certainly state his fear then.

If the patient's worry is related to the pain involved, a casual remark to the effect that there is enough anesthetic will help his peace of mind. If it is fear of the needle prick, a topical anesthetic and a small, sharp needle will eliminate a good deal of the discomfort. Here is one point that should be considered in discussing the needle. The dentist simply must not promise absolute freedom from pain, for there is some discomfort although it is usually slight. Consider the nervous patient and his feelings when the operator's injection does hurt slightly even though he said it would not. Immediately all confidence is lost. Any promise of complete anesthesia is disbelieved. If the dentist glosses over the needle pain, calling it nothing, the patient wonders what the operator *does* consider pain, and is off on a tangent of imaginary blood and horror that renders him a fidgety wreck who shrinks at the mere approach of an instrument.

It is much better for the operator to promise extreme care and that he will prepare the patient when any discom-

fort is likely. Then if the injection can be given with a minimum of pain, the patient is heartened by finding the dentist even better than his promise. If there is some pain experienced, the patient has at least been prepared for it, and he will reason that the operator is not one to misrepresent things, and that since the dentist was truthful in this, his promise of almost certain freedom from pain in the actual extraction must be true and he is likewise encouraged.

While waiting for the anesthetic to become effective, or while injecting it, something may be said about giving additional procaine if it is needed, thereby averting a possible loss of confidence in the operator if it is necessary to reinject. Napoleon realized that a wise general always provides himself with a means of retreat, and the average dentist will find it to his advantage to do likewise.

After injecting, and at the time when anesthesia should be complete, it is well to test the surrounding soft tissue for anesthesia with an explorer point. If the pricking of that instrument is not felt the patient gains confidence for the actual extraction. He reasons that, if the ordinarily painful pricking is painless, the extraction should also be painless.

If, on beginning the forcep application, the tooth appears likely to fracture in the extraction movements, a warning of that danger may be given, and at the same time something should be said that will hint that that contingency does not especially worry the operator. A warning of this kind may save a scene. Who has not seen a frightened patient sit up trembling when a t o o t h breaks and ask, hopelessly, "What are you going to do now?" And who has not frequently seen the difficulty of quieting such a person into a state that will permit the removal of the roots. If he is ready for such a difficulty, and knows the dentist will confidently deal with it, he will suffer the removal of roots with comparative composure.

The patient who is afraid of appearing to disadvantage during extraction is not so rare. Usually his difficulty is a penchant for fainting at the slightest provocation. These people will virtually always mention their difficulty before anything has been done. Here, too, the dentist must e m a n a t e confidence. He should promise great care in operating, and a use of less procaine than in the ordinary case. Placing the patient in a horizontal, or in a semi-horizontal position, and injecting slowly will help the person to remain conscious. If the operator makes it known that he recognizes the

patient as someone needing care, and that he intends to give it, he immediately gains the confidence of the fainter.

Perhaps the fear of the esthetic effect on the patient after the extraction is usually secondary to the fear of pain, but it will do no harm to allay apprehensions on that point. Often the patient will ask what is to be done to replace the lost tooth, even before it is out, and the dentist can then explain that the means of restoration will be either a bridge or denture. If that contingency has bothered the patient it will crop out in the conversation, or the dentist may introduce it himself if the person seems too timid to ask questions.

The fear that the extraction will harm the adjacent teeth almost belongs with some of those bordering on superstitions, and the only means of defeating them is to contradict them firmly. Some of the more simple persons positively will not forsake a foolish idea, but the humor furnished the operator in contemplating the possibilities of a wobbly mind's imagination will compensate for the difficulty in operating on these persons.

As has been indirectly mentioned, perhaps the most efficient means of quieting a nervous person's fears is a noticeable confidence on the part of the operator. To be most effective the confidence must be genuine, for an ostentatious confidence that is really assumed is rather easily detected. This genuine confidence can come only after the operator has dealt successfully with enough cases to prove to himself that he is able to do what is necessary under the trying conditions that may develop during some extractions.

No doubt the dentist who is most lacking in the confidence that comes from experience is the recent graduate, and that is greatly to his detriment if he is practicing alone, for there is no time in which the patient is more critical or more likely to notice a lack of confidence on the dentist's part than during an extraction.

A study of techniques in extracting and injecting will bolster a confidence that is not backed by experience. In baseball the wise player settles in his mind the proper play to make before the ball comes to him. Then, if it does come in his direction, he makes the proper move without taking time to think. The dentist can follow the ball player's practice by considering all possible contingencies before hand, and then if one appears he can readily deal with it.

35 Morningside
Savings Bank Building
Sioux City, Iowa.

OHIO FALLS IN LINE

By L. B. PODIS, D.D.S

Strangely enough, it took only a few months for ethical dentistry to win out over the "advertisers."

■In the April, 1934, issue of ORAL HYGIENE[1] I made the following statement: "I maintain that a closely-knit organization of dentists, headed by an aggressive leader, can eradicate that menace to the dental profession—the advertiser—by national or state legislation . . ." Exactly a year later the state of Ohio placed upon its statutes amendments to the dental law which embody principles forever curbing the practices of the charlatan and quack.

The strangeness of the situation lies in the fact that it took, not years, but only a few months to bring organized dentistry to the concerted action necessary to enact the new dental law, resulting in a complete victory for ethical dentistry.

In retrospect, it is amazing to visualize the power that lies in organization. Like a chained, sleeping giant, the good that is in unity lies dormant. Presently the giant, prodded into action by adverse conditions, bestirs himself, stretches, and with little effort casts off the shackles of mediaevalism that bind him.

The analogy is perfect. For many years organized dentistry in Ohio had slept while the public was being seduced with lurid, blatant advertisements, such as: "Guaranteed, solid gold bridgework, $2.95"; "plates made of best materials and warranted to fit, $8.75"; "free gold crowns to the first fifty people attending the opening of Doctor Shaper's new dental parlors"; "marvelous new light cure for pyorrhea, only 50 cents per treatment"; and so on ad nauseam.

[1]Podis, L. B.: Organizing the Dental Profession, ORAL HYGIENE In Dear Oral Hygiene 24:554 (April) 1934.

Ohio has for a long time groaned under the load of bucket-shop dentistry inflicted upon a never-ending stream of humanity wending its way to the advertising office, in answer to bait advertisements. Even the radio, modern carrier of sweet music and enlightened entertainment, had allied itself with the newspaper, to drum into the ears of listeners in every home the story of the joy that came to Mrs. Brown when she had a tooth extracted "scientifically and skilfully" at Doctor Skinner's, for only 25 cents.

Then without a warning, as it seemed, sleeping public sentiment was awakened. The impossible has now happened. With one mighty stroke of the lawmakers' ax the bonds that fettered decency in dental behavior are shattered, and the dental profession rises in the public eye to the position it rightfully merits—that of a respected healing profession.

Let me recall a few of the interesting facts that permeate the drama entitled "Ohio Falls in Line" or "Elevating the Dental Profession." Dentists in Ohio were aware of the fact that in a few states laws existed regulating advertising dentists. The far-seeing men in our profession dreamed of the day when the people in this state would be protected against the unscrupulous practices of a few—but that time seemed infinitely far off.

The Cleveland Dental Society, largest of the components of the Ohio State Dental Society, an American Dental Association affiliate, had hitherto maintained a "hands-off" policy in the matter of economic endeavor for its members. Technical and scientific advances were its prime reason for existence up to this time. But the rumblings of discontent were becoming evident, and a sharp decline was observed in the membership. Then, too, the news filtered in that another dental organization was in the making; that hundreds of Cleveland dentists had signed cards indicating their willingness to join this organization dedicated to the economic betterment of its constituents; that this new organization was taking upon itself the duties of vigilantes, exposing illegal dental practices; that this new group planned to become statewide in its scope.

Draft Amendments

Simultaneously things began to happen. In Columbus, the House of Delegates of the Ohio State Dental Society began to study a rough draft of proposed amendments to the existing dental law of Ohio. On December 16, 1934, the Committee on Legislation of the

Ohio Dental Society, headed by Doctor Frank M. Casto, now president of the American Dental Association, met with the Ohio State Dental Board and adopted these roughly drawn amendments. Word was passed to the larger component societies in Cleveland, Cincinnati, Akron, and Toledo to send their legal advisors to a conference to draw up these proposed amendments in proper legal form. The ball had now begun rolling, with momentum that gained steadily until victory was assured.

On January 27, 1935, the Ad Interim Committee of the Ohio State Dental Society approved the legal draft and instructed the Committee on Legislation to introduce the amendments in the present session of the legislature. State representative William Hudlett of Cleveland was selected to introduce the bill, now termed the Hudlett Bill No. 145, in the house of representatives. Senator J. G. Lowery was selected to do the same in the state senate.

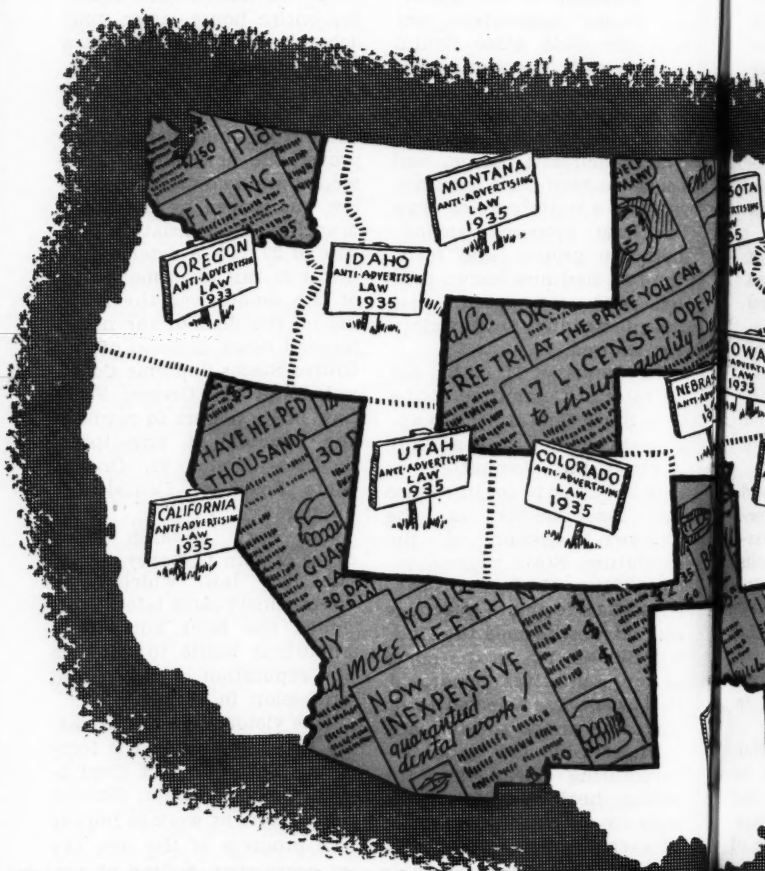
Under Ohio law a bill incorporating ideas for the public health welfare first goes to a Health Committee of each branch of the legislature. If reported favorably it goes to a direct vote by members of the legislative body. After several hearings the house of representatives Health Committee, on March seventh, passed the proposed amendments by a vote of 12 to 2. On March nineteenth, the entire house, after some debate, passed the bill by a vote of 115 to 6. The first hurdle in the race was passed.

In the senate, the Health Committee unanimously approved the new bill on April second and two days later the law was passed by the upper branch of the legislature by a vote of 29 to 0. A determining factor in this unanimous vote of the senate was the reading on the floor of the newly handed down decision of the United States Supreme Court, upholding the Oregon State Law in its powers to regulate the conduct of advertising dentists—Semler vs. Oregon State Board of Dental Examiners.[2]

On April eleventh Governor Martin L. Davey signed the new law, which took effect ninety days later. Thus ended the brief but vitally important battle to enhance the reputation of the dental profession in Ohio.

The victory was not as easily accomplished as the foregoing matter-of-fact description would indicate. Sinister forces were at work to impede the progress of the new law at every step. A fund of several thousand dollars was raised by the advertising dentists in this state, and political

[2]Editorial, Mr. Chief Justice Hughes Gives an Opinion, ORAL HYGIENE 25:832 (June) 1935.



This map has been prepared through information obtained from sources that we believe to be reliable, including the files of the American Dental Association. The states indicated have within recent years strengthened the advertising provisions in their laws. If there are any other states that have passed anti-advertising laws and are not included in this map, we shall appreciate receiving the information.—The Editor.


MAINE
ANTI-ADVERTISING LAW 1935
NEW HAMPSHIRE
ANTI-ADVERTISING LAW 1935
MASSACHU
ANTI-ADVERTISING LAW 1935
RHODE ISLAND
ANTI-ADVERTISING LAW 1934
NEW YORK
ANTI-ADVERTISING LAW 1935
NEW JERSEY
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DELAWARE
ANTI-ADVERTISING LAW 1933
MARYLAND
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MICHIGAN
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WISCONSIN
ANTI-ADVERTISING LAW 1933
OHIO
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INDIANA
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ILLINOIS
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MISSOURI
ANTI-ADVERTISING LAW 1935
TENNESSEE
ANTI-ADVERTISING LAW 1935
FLORIDA
ANTI-ADVERTISING LAW 1935
X RAYS
Painless
NEW SCIENTIFIC
REE TRIAL
Extracted
CHEAP

intervention attempted to thwart the impending bill. At times it looked dark as wrangling over technicalities became apparent in the legislative committee rooms. In Cleveland, Doctor H. J. Hoppe, President of the Cleveland Dental Society, a zealous worker for the bill, did yeoman work in whipping enthusiasm to a fever pitch by addressing dental mass meetings and dental fraternal organizations. Letters were sent by the Cleveland Dental Society to all Cleveland dentists advising them of the progress of the bill and urging them to flood the law makers with telegrams, letters, and long distance calls. The same policy was adopted by heads of component societies in other parts of the state, with the result that a keen influence was making itself felt in legislative halls. That these tactics bore fruit is evidence of the fact that even the bill's fervent supporters did not think it could be an accomplished fact the first time it was proposed to the legislature.

Studied Other Laws

Now as to the amendments themselves: When the Committee on Legislation of the Ohio State Dental Society met to consider the much needed remedies to existing evils, it had before it copies of the dental statutes of many states, notably New York, New Jersey, Missouri, and Oregon. In addition, recent legal tilts with offenders brought to light glaring deficiencies in the existing Ohio law. It was therefore a simple matter to cull from prevailing time-proven laws of other states the most desirable provisions, in order to pattern a model reform bill for Ohio.

Following are the high spots in the recently enacted law, couched in extra-legal language:

1—The state dental board may hear testimony in matters relating to the duties imposed upon it by law, and *the president and secretary may administer oaths.*

2—The state dental board shall have the power to require attendance of witnesses and production of records and take deposition of witnesses.

3—The secretary of the board may *issue a subpoena for any witness* in the same manner that a subpoena in a criminal case is issued.

4—An annual registration fee of three dollars shall be paid to the secretary of the Ohio State Dental Board. (The hitherto nominal fee of one dollar every five years was wholly inadequate to properly police the dental offenders in this state.)

5—The state dental board may warn, reprimand, *revoke*

or suspend a license for the following infractions:

(a) conviction of moral turpitude

(b) violation of any law regulating the practice of dentistry

(c) chronic inebriety or addiction to drugs

(d) advertising statements tending to deceive the public

(e) false statements of superior skill or knowledge

(f) advertising by means of large display, glaring light sign, or sign containing figures of teeth, bridgework, or any portion of the human head

(g) employing advertising solicitors or publicity agents

(h) advertising free dental work or free examination

(i) advertising to guarantee any dental service

(j) advertising to perform any dental operation painlessly

(k) employing an unlicensed person to perform dental operations

(l) conviction of gross immoral conduct

(m) All advertising by any medium whatsoever, including radio, must conform to the above section.

6—Practicing under the name of a company, association or corporation is forbidden under penalty of fine or revocation of license.

7—*A dentist shall not advertise his name in connection with any office unless he is himself personally present in that office a majority of the time the office is operated.*

From the foregoing it may be seen that the dentists of Ohio have placed "teeth" in the new dental code regulating the conduct of the unscrupulous members of their profession. There can be no doubt but that this marks a milestone of a new era in professional relationship between the dentist and his patient.

Ohio now takes its place in the lineup of states which have enacted similar laws. It is hoped that this memorandum will convey to members of the dental profession in states where the dental profession is similarly minded a clear idea of what transpired in the process of arriving at the desired goal.

8612 Hough Avenue
Cleveland, Ohio.

EDITORIAL COMMENT

Give me the liberty to know, to utter, and to argue freely according to my conscience, above all liberties.—John Milton

DESPOILERS

■ Each month Doctors Smedley and Warner, the editors of the ASK ORAL HYGIENE department receive a volume of correspondence from dentists in all sections of the country. The greater part of this correspondence pertains to technical questions on clinical procedures or requests for information on unusual or difficult cases. Each letter is answered as promptly as possible. A small part of the correspondence is published in the pages of the magazine.

In this particular issue queries from dentists in the states of Iowa, Kansas, Maine, Missouri, North Dakota, North Carolina, and Pennsylvania are published on such diverse subjects as discolored gingival tissue; anesthesia; systemic poisoning from amalgam restorations; hypersensitive gums; and malocclusion.

One letter that is not published but which merits unfavorable editorial comment concerns an incident that is not complimentary to the professional tradition. A dentist in a state in the Northwest who was puzzled by a severe case of mottled enamel wished to render his patient a service of a quality consistent with the professional ideal. He was informed that another dentist in a proximating state where the condition of mottled enamel was prevalent had developed a technique

of treatment that apparently was new and successful. Acting under the spirit of professional tradition the dentist wrote a courteous letter directly to his colleague asking for specific information on treatment. The reply received was pompous, evasive, cryptic. This dentist admitted that he had a successful treatment but was not anxious to reveal its nature. Although no bald, over-the-counter offer was given, the suggestion was deftly made that for a consideration the treatment might be revealed. The developer of the alleged treatment had a sharp eye on the box office!

Unfortunately this incident is not particularly rare or unprecedented. We have uncovered evidence of other dentists who were peddlers in thin disguise; who were selling wares without the courage to hawk openly or display the signs of the merchant. If there is an American caste system, it does not discriminate against the candid merchant. Few persons have criticism for the honest merchant or for ethical merchandising practices. It is also true that few persons object to inventors protecting their rights against predatory infringers by the use of patents. Instruments, appliances, materials used in dental practice are generally protected. Techniques, processes, and methods for the treatment of disease, although they may be legally patentable, are *not* subject to patent in the spirit of the professional tradition. This principle was established by the profession in the vulcanite and inlay litigation. Dentists are willing to pay royalties to inventors of *things* but not willing to pay in perpetuity for the *use* of processes or techniques. Any dentist who attempts to exact a tribute from another dentist by holding up the lure of the mysterious, occult, hocus-pocus is not a part of the professional tradition but a vestige of the patent-medicine faker.

Some of the most eminent men of the dental profession offer courses in technical instruction under the auspices of dental colleges or study clubs and a few, under commercial sponsorship. For this service they receive compensation—generally

not enough. Only those dental Pharisees, who live in the rarefied air of the holy of holies and are "unlike other men" because of their ability to exact huge fees from private patients, cast aspersions on these dental postgraduate teachers who teach for compensation. (The zeal of the dental Pharisee may often be expressed mathematically: it is in direct proportion to his income from a successful practice. The higher his fees, the more intense his desire to "purge" and regulate the lives of dentists lower in the economic scale.)

So long, however, as these postgraduate teachers give dentists information that is practical, sound science, not tied up with secret processes and nostrums, and does not represent subsidized undercover selling, they are giving a genuine service. Commercialism in teaching is deplorable—if it is a secret rapport between a dental college dean and a supply house in the matter of student instrument lists; or a preferential puff linking an editor of a dental society publication and a manufacturer; or a dentist who lures his colleagues to his office with promises of the bizarre, the mysterious, or the sensational in the treatment of disease. In the foregoing categories of dean, editor, and dentist—all three are despoilers of the professional tradition.

Edward J. Ryan

Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply. Material of general interest will be published each month.

EFFECTS OF PROCAINE

Q.—A patient, a man about 35, came in for extraction of the lower second molar. I used mandibular nerve block, 1½ cc. procaine solution. The ampule contained procaine, .02 Gm. (2% solution); epinephrine .00002 Gm.; chlorbutanol, .005 Gm.; Ringer sol. Q. S. 2.5 cc. to ampule, which gives 1/3000 Gm. of epinephrine to each cc.

Following the injection the patient complained of feeling nauseated and his face and lips took on a yellowish cast; he became weak; his pulse dropped to 45. I gave the patient aromatic spirits of ammonia internally and by inhalation, but he seemed to get worse instead of improve. A physician was called in for a heart examination but no cardiac disturbance was indicated. The physician said it must be the procaine that caused the depression as the epinephrine should have increased the heart action. The patient seemed to be all right the next day and went back to work. What would you say was the cause of this condition, and can you suggest a remedy for it?—I. S. F., Florida.

A.—The case described in your letter is interesting in itself and because of the symptoms occurring so rarely after the use of procaine.

Angeoneurotic edema, asthmatic attacks, or other serious manifestations have been reported in the literature but we have never seen such a case.

H. D. Coffee, M.D., of the United States Veteran's Hospital, Waukesha, Wisconsin, reports using procaine infiltration for herniotomy in a white man, 38, in good physical condition. Thirty-six hours after the operation he started to cough and raise large quantities of seropurulent sputum. This was accompanied by a rise in temper-

ature to 101 degrees F., cold skin, and profuse perspiration. The cough continued and the temperature increased to 103°F., when forty-eight hours after the operation symptoms subsided except for a slightly productive cough at the end of four days. In similar cases the patients have had prophylactic treatment which has resulted in their having no more severe reactions.

Edward G. Martin, M.D., Detroit, Michigan, writes in the November, 1930, issue of the *Journal of the Michigan State Medical Society*, on the subject, "Local Anesthetic Idiosyncrasies; Treatment." In this article he describes symptoms following the use of procaine of "irritation of the nerve centers, disclosed by convulsions of the clonic type and final paralysis of respiration; a marked lowering of blood pressure." Doctor Martin advises the use of barbituric acid derivatives by mouth, one-half to one hour before using procaine as a preventive of unpleasant symptoms, although he recognizes that unfavorable results are due to idiosyncrasy rather than general toxic effect of the drug itself. The barbiturics can be used intravenously to overcome the effects of procaine just described. The accompanying bibliography[1] will give additional information.—GEORGE R. WARNER.

AMALGAM RESTORATIONS

Q.—I read recently in a medical journal that mercury in amalgam restorations might be the cause of certain general systemic disturbances, but how could that possibly happen when it is in *chemical* union with the alloy, and even if it were not, mercury is insoluble in saliva or the gastric juices—in fact is sometimes used as a cathartic by "virtue of its weight."

Would not a restoration show the *loss* of mercury if such a change should miraculously take place, and if mercury were soluble (which it is not) would it not be beneficial rather than otherwise?—H. C. S., Massachusetts.

A.—I quite agree with you as to the improbability and even impossibility of systemic poisoning from amalgam restorations. The union between the alloy and mercury is physio-chemical and can be broken down only with high heat or corrosive acids.

Much has been written on this subject but I have never seen anything at all convincing or scientific. The articles have been largely expressions of personal opinions or citing

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[1]James, B. M.: Procaine Dermatitis, J. A. M. A. 100:440 (August 25) 1931. Waters, R. M.: Procaine Toxicity, Its Prophylaxis and Treatment, J. A. D. A. 102:2211 (December) 1933. Histopathologic Changes in the Nervous System Caused by Procaine Hydrochloride, Jap. Pathological Soc. 21:622-632, 1931. Influence of Ether on Toxicity of Novocaine, Brit. J. Anes, Pages 67-73 (January) 1931.

cases in which the removal of amalgam restorations was followed by improvement in the health of the patient. These latter cases lacked controls, and the improvement might have been imaginary or coincidental.—GEORGE R. WARNER.

HYPERTROPHY OF GUMS

Q.—Under separate cover I am sending you a model of a case showing hypertrophy of the gums around the upper incisors and cuspids. The gums are firm.

The patient is a boy, 18. There is no calculus, and I can find no cause for this condition.

His twin brother had some trouble two years ago. I was forced to trim the gums at that time, but his gums are normal now.

What could be the cause of this hypertrophy, and what is the proper treatment?—H. G. E., Arkansas.

A.—The hypertrophic gingivitis, described in your letter and shown in the plaster model which you sent, is what is known as the idiopathic or endogenous type. It occurs in young persons, more frequently girls, and usually disappears spontaneously in the mid-twenties. Aside from frequent prophylaxis treatments and good home care of the mouth, there is nothing to be done.—GEORGE R. WARNER.

COLOR OF TEETH

Q.—One of my patients has asked me concerning the application, topically, at intervals of six months to a year, of some material on vital teeth to improve their color and appearance.

Are you familiar with such a treatment? If so, please give me the particulars.—R. R. M., Indiana.

A.—We know of no substance to be applied topically that will improve or change the appearance of the teeth unless it results in the removal of deposits, stains, or mottling, that is to say, if the teeth are normal natural teeth, even though the hue is more yellowish, bluish, or greyish than the patient likes, there can be no change made by any topical application.

The advertising matter in relation to dentifrices which leads people to believe that the use of certain dentifrices will whiten their teeth is misleading and untrue. Hydrochloric acid with some other vehicle has been used for the purpose of whitening teeth, but as you know this simply means a decalcification.—GEORGE R. WARNER.

MALOCCLUSION

Q.—I have a patient, a boy of 9, whose bite is so close that the erupting lower centrals strike the gum tissue of the palate back of the superior centrals, and the resulting trauma causes considerable irritation. Opening the bite does not seem to be feasible for a boy that young. Have you had a like experience and what

would you suggest?—P. H. S., Iowa.

A.—This boy undoubtedly should have the services of a competent orthodontist. His is probably a case of Doctor Angle's Class 2 malocclusion or a distal occlusion of the mandibular teeth in which case the erupting lower incisors do not contact the lingual surfaces of the upper incisors as they normally should and consequently have erupted to a point where they strike the upper gums.—V. C. SMEDLEY.

PENNSYLVANIA ISSUES NEW E R A FEE SCHEDULE

A new schedule of fees for services given to the recipients of emergency relief in Pennsylvania was completed recently by a committee selected from the board of trustees of the Pennsylvania State Dental Society with R. M. Wallis, D.D.S., as chairman, working in cooperation with the committee on emergency relief of that Society.

Concerning the basis for this fee schedule, the members of the committees realized that the dentists in other states are receiving larger fees, but they were forced to consider the fact that in the state of Pennsylvania, under the present constitution, money for relief can be raised only by taxation: while in other states, bond issues are possible for the raising of large sums of money.

This schedule, which went into effect on August first, increases the fees and widens the scope but in doing so it places certain controls.

Regulations Governing Emergency Relief Dental Service in Pennsylvania:

1. Dental care must be a minimum and never exceed ten dollars on one dental order.

2. If the dentist cannot attend the patient the day the order is presented at his office, he must indicate the date the order was presented, make an initial appointment date, retain the order, and perform the work at the time specified.

3. As a routine procedure, and in accordance with good dental practice, ample instructions in oral hygiene and home care should be given to every patient presenting a relief order.

4. EXTRACTIONS: For an emergency extraction, when dental order is presented, including cost of local anesthetic, not more than $1.00 for the first tooth and not more than $1.00 for each additional tooth; not compensable beyond three without authorization, provided, that the maximum charge for one dental order, including full mouth extraction, even if authorized, shall not exceed $10.00.

5. Only in extreme cases should all teeth be extracted as there is no provision for the making of any restoration, and if done as a part of a general health condition, it must have been after a consultation with, and certification by, the attending family physician. A general anesthetic if authorized, may be used and is compensable at the rate of $2.00 per case. In exceptional

cases only can a charge be made for preoperative or postoperative care and must be authorized by the local Advisory Committee.

6. HOME VISITS: Will be paid for at $2.00 per visit, limited to postoperative hemorrhage.

7. IMPACTIONS: Maximum fee, including x-ray, shall not exceed $5.00.

8. FILLINGS: Fee $2.00 per tooth. More than one tooth must be authorized by the local Advisory Committee.

9. PROPHYLAXIS: Not in program.

10. GINGIVITIS: Not in program.

11. PYORRHEA: Not in program.

12. DENTAL X-RAY: Not within the scope of the Emergency Relief Program.

13. DENTURES AND BRIDGE REPAIRS: For an authorized emergency repair of an existing denture or bridge $3.00 plus $.50 for each additional tooth or facing, but not to exceed $5.00.

14. RECEMENTING CROWNS OR BRIDGES: Fee $1.00.

15. SPECIAL CASES: All special cases not covered by these regulations must have authorization from the Harrisburg Office in advance.

16. When a general anesthetic is requested, a statement explaining the necessity must be signed by the requesting dentist; authorized in writing by the local Advisory Committee and be attached to the dental order when presented for payment.

17. CYST REMOVAL: Usual office fee of $1.00, but not to exceed $5.00.

18. FRACTURED JAWS: For an emergency fractured jaw, (Minimum Service in accordance with good practice to be given), fee not to exceed $20.00.

19. ROOT CANAL THERAPY: Not generally allowed; is to be authorized by the local Advisory Committee in advance. Fee including root canal filling and filling of tooth not to exceed $5.00.

20. INCISING ACUTE ABCESSES: Fee $1.00.

21. VINCENT'S INFECTION: Usual $1.00 office fee, but not to exceed $10.00. To be compensable the dental order is to be accompanied by a positive report from an approved pathological laboratory, if and when demanded by the local Advisory Committee. or the Relief Administrator.

22. When the word authorization is used, it means that the local Advisory Committee must be sufficiently familiar with the condition to justify the ordering of the dental work and plainly record this authorization. in ink, on the face of the dental order before the work is done, or the committee man who gives this authorization verbally. or by phone, must at the time make written note of the same and present this documentary evidence to the Relief Director and the other members of the committee at the time the bill for the dental order is considered and from this record the authorization shall be transcribed on the dental order. The local Advisory Committee cannot approve dental work coming under authorization in any other manner.

23. When additional members of a family on relief are accepted by a participating dentist. there will be no reduction from the fees as given above.

24. In accepting a dental order you certify to the fact that you are familiar with the Rules and Regulations governing general medical and dental care given to relief recipients and you will accept the decision of your County Advisory Committee and/or the Relief Administration.

25. The local and/or State Dental Advisory Committee are to be nominated by the local and/or State Dental Society and must be acceptable to the State Relief Administration.

26. The local Advisory Committee, the State Advisory Committee and/or the Relief Administration may apply any rule applicable to the general Relief Program. including economic limits, to any participating dentist. and may suspend or permanently remove dentists from the list of participants on account of failure to cooperate with the local Advisory Committee, or if irregularities are disclosed.

DEAR ORAL HYGIENE

"I do not agree with anything you say, but I will fight to the death for your right to say it."
—*Voltaire.*

A COLLECTION PROBLEM

After completing a full denture for a patient I received a down payment and a promise that the balance would be paid within two weeks. Following four months of broken promises (and there were quite a number) I turned the account over to an attorney for collection.

Upon receipt of a second notice from my attorney, the patient in company with her mother, came to my office and demanded the return of her money. I informed them that the case was in the hands of my attorney and that I would abide by his decision. Both left my office threatening to "get even."

Within a few hours a warrant for assault in the third degree was sworn out for me. The patient claimed that she and her mother came to my office and demanded the return of her part payment because the denture I made for her was faulty. Of course I was placed under arrest.

On the day of the trial the patient and her mother withdrew the charge and gave me a signed statement that branded them as perjurers. I then took the matter up with my insurance company and also with the chairman of the insurance committee of the dental society—and I am sorry to say that both of them ran out on me.

The point I wish to bring out is this: Had the patient decided to sue me as a result of faulty work my interests would be amply protected by the insurance company; and besides the patient knew that it would be next to impossible to prove that the work was faulty. Instead she decided to take the easiest way out: first hold me for assault; and if successful then sue me in a civil action. Therefore, it is the patient that decides whether or not the insurance company protects one.

Should this new racket be allowed to flourish, malpractice suits will become a thing of the past.—W. FRACHTMAN, D.D.S., *Pearl River, New York.*

DENTISTRY'S FUTURE

In reviewing the past few years of dental privation; the hard-

ships through which many dentists have gone; the loss of practice; the curtailing of expense attendant thereto; the insistent demand of the landlord; the worry of the unpaid house rent, or the payment on the home—it would seem that the dental practitioner should have the same regard for the benefits to be derived from a "united front" as the many organized tradesmen.

It is a revelation of stupidity to one who tries to understand the psychology of the average dentist who belongs to a state dental organization, or more likely none at all, and who perhaps, once a year, goes to a state meeting; but who, aside from this, is not enough interested in his own personal welfare to unite himself closely to his fellows, and to his community, to the end that he may with others in an organization *demand* from his legislators such fair legislation as shall protect not only himself, but the public which he serves.

There is too much attention paid by the individual dentist to the business of the moment, and too much trust placed in Doctor Some-James who is willing, without pay, to do all of the wheel-horse work. These wheel-horse men are also busy in their private affairs, and it must be admitted are the ones who are the most generous in the giving of their time. Certainly a half dozen men cannot be expected to attain, or hope to attain, alone, the results that might be expected if all would do their just part. In the face of the jittery feeling that every dentist in the United States has, that his profession may be commandeered by the state either in the way of insurance, panel or otherwise, still he, with few exceptions, continues to jitter and jitter, but makes no sustained effort to get in closer touch with his own organization for his own personal protection.

At a recent state meeting where some one thousand or twelve hundred dentists were g a t h e r e d the president-elect asked that each and every member present send a telegram, which would cost perhaps thirty-five cents, to his Senator, requesting that he support the bill for organized dentistry. This president-elect said that only six telegrams were sent from this great number of men. It seems unbelievable that these dentists would not in greater measure support their own interests.

Newspapers and the radio for their own financial objectives support their own interests and reach a far greater number of people each day than do the dentists.

What is the answer? Shall organized dentistry, which has made possible the education of those who have turned traitor to their educators, continue to depend on a few men to defend them from those who advertise their wares, or shall the great mass of organized dentists sufficiently assess themselves to make more profitable the attention of our advertising agencies?

There is a choice of paths: Either organized dentistry must charge itself enough to raise sufficient money to attract the radio and the daily publications, and thereby get the support of the propagandized public, or it will inevitably be among the first to sink along with the physicians

into the maw of some sort of socialism. These professions are the least organized, and by this token are the least able to fight.

The Longshoremens' Union should show to any doubter what close organization can accomplish. This group presents a united front.

In Stockton, California, two or three years ago, at a meeting of the Taxpayers League, there was a discussion of how best to reduce the operating cost of the city government. One gentleman, who was frank and honest in his views, said: "My suggestion is that we concentrate on the street-sweepers, and the janitors of the different public buildings, because they are the least able to fight."

The inference was, that if this battle was won, then another and a higher group might be attacked.

So it is in the present unsettled state of society. If the physicians and dentists could be brought into government control, it is then but an entering wedge for further and more drastic legislation. There is only one solution to the dilemma. Assess every dentist in the state, through organized dentistry, a definite amount sufficient to make more profitable to the advertising agencies the support of the best dentistry in the world today. Publicize this dentistry which was pioneered and produced by ethical dentists in the United States, and this dentistry which owes no major invention or improvement to those who at present advertise it. As to those who do not assume this assessment in this cause, their position should be made untenable in their respective communities.

The professional outcry of some can be heard: "Oh! tut, tut, this is a profession; it is not a trades' union. Charlie Jones can't pay that amount. He hasn't made a cent in two years. Look at Frank Smith, he is in a bad way."

These boys, like the rest, had enough funds to go through college. Surely then they can procure the few necessary, urgent dollars to protect their own original investment.

There is a tentative plan in which is advocated the placing of the state in charge of the collecting of funds through annual renewal of licenses; these funds to be assessed to all dentists alike. It would appear that this plan would place the dental profession in the hands of the state with some sort of state control to collect this money. It seems that this method would be inimical to the best interests of dentistry, in that it would take the administration of dentistry out of the hands of dentists and place it in the hands of a state commission; members of which, not being dentists, would not be able to judge our profession fairly. Dentists know dentistry and its problems and should handle them far better than laymen can.

Ask yourself these questions:

Will *I* be hurt if dentistry is taken over by the state, and *I* am put into competition with the lowest bidder for insurance dentistry?

Will *I* be hurt if the state tells *me* how much *I* can charge for *my* services?

Will *I* be hurt if the state takes over dentistry and dentists in toto?

These eventualities are at the

threshold of your office door.

Will dental manufacturers and dental distributors be hurt if you lose your job and are assigned another? Answer: They will not, because dental supplies and equipment will still be sold.

Will dental colleges educate fewer students? Answer: They will not, because students will still be found to compete, after graduation, for the lesser fees.

Will the public be hurt if you are compelled, in your new job, to compete for amalgam restorations at 25 cents each, or will the public be hurt if you get $100.00 per month for your services to the state? Answer: They will, because lesser fees will degrade dentistry under state or panel control to the level of the lowest competitive bidder. Take your choice; it is your problem. Wake up and organize for your rights; for the best rights of better dentistry; for the best interest of the layman, and for the further advancement of better and better dentistry.

In connection with the foregoing statements I wish to add that I will cooperate in any manner possible in this, or a better plan. Constructive comment is invited. — EDWARD CURETON, D.D.S., 2210 *Pacific Ave., Stockton, California.*

DENTAL CARE FOR THE INDIGENT

Doctor William P. Heffernan's[1] letter in the July issue was disappointing in its unsound economics and bitterness against a group of indigents on relief rolls.

It seems to me his title should have read, "Let the Unemployed and Indigent Come to us Private Practitioners—Regardless of their Incomes—and Let All Clinics go to Blazes so as to Prevent Any Inroads on our Earning Capacity."

Can one-third of the population of Somerville be not at fault and yet be "parasites, chiselers, leeches, lazy, inefficient, and loafers"? The function of a government is not merely to relieve pain, but to preserve, maintain, and restore the health of the citizens. And most emphatically dentistry should not be a luxury —to any extent. Adequate dentistry should be within the reach of all the people for it is an essential necessity.

Irrespective of the income earned by directors of clinics and forgetting the very few who take advantage of private or fee clinics, we still need to find a method to enable more than eighty per cent of our people to secure adequate dentistry. Destroy all clinics! What have you to offer in their place? Think less of your earning capacity and more of the great need for dental service —health services.—EDWARD FEFERHOLZ, D.D.S., 140 *Irving Street, Rahway, New Jersey.*

[1]Heffernan, W. P.: Let Us Do Something for the "Forgotten Man" ORAL HYGIENE In Dear Oral Hygiene Department 25:990 (July) 1935.

DENTAL COMPASS

SEEK DAMAGES FOR INJURED TEETH

The battle over the water supply in Chetopa, Kansas, that started several years ago, culminated recently in the filing of claims totaling $50,000 against the city of Chetopa for injuries to teeth which two children, it is alleged, sustained as a result of drinking water containing a high percentage of fluorine. Behind these claims lies an interesting story of a dentist's fight against mottled enamel as told by J. Scott Walker,[1] D.D.S., in the March, 1934, issue of ORAL HYGIENE.

The claims were made, according to a story in *The Parsons Sun*, Parsons, Kansas, by Daisy Dean Ditzler, 17, through her father, Francis Ditzler and by William Ramsey, 11, through Caesar Ramsey, his father. Each of the plaintiffs seeks $25,000 from the city of Chetopa for the "loss, injury and destruction of their permanent teeth and bones."

The city has thirty days in which to answer the claims. If no settlement is made, a suit probably will be brought in district court to secure the damages asked.

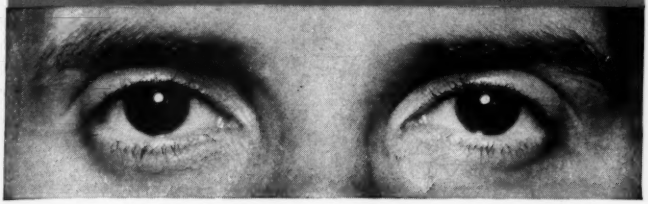
Mayor George Columbia said that the city council has under consideration a proposal to make tests of the water from each of the veins of the wells from which Chetopa obtains its water supply. The purpose will be to ascertain whether or not fluorine is present in both veins. Should the analysis reveal the presence of fluorine in one and not in the other, the city would case off the faulty vein and use water from the other one. For several years attempts have been made to change the Chetopa water supply; two bond elections having been held for this purpose. Each time, however, the proposal to build a new water plant on the Neosho river has been defeated.

As long ago as 1932 Doctor Frederick S. McKay, consulting specialist in child hygiene for the United States public health service; Miss Selma Gottlieb, state chemist; and R. E. Lawrence, assistant engineer for the state board of health, visited Chetopa and conducted a thorough examination of the city's water supply. Doctor McKay also examined the teeth of a number of children and, after finding a number of cases of mottled enamel, he and the two state officials urged the Chetopa residents to change their water supply, as the flourine content was sufficient to menace the health of persons there, especially children. At the last session of the legislature a bill proposing to give the state board of health authority to order a change in Chetopa's water system was introduced and passed the senate by a large majority but was killed in the house.

Those who wish to preserve the source of the present water supply argue that, with the exception of the flourine, the Chetopa water is excellent. Advocates of a new water system

[1]Walker, J. S.: One Man's Battle Against Mottled Enamel, ORAL HYGIENE 24:341 (March) 1934.

YOUR INCOME DEPENDS UPON THESE



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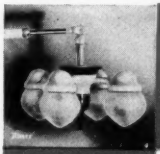
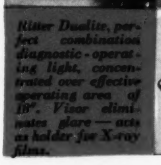
EYESTRAIN brought on by improper light is robbing dentists of a goodly proportion of their income and causing needless mental and physical fatigue.

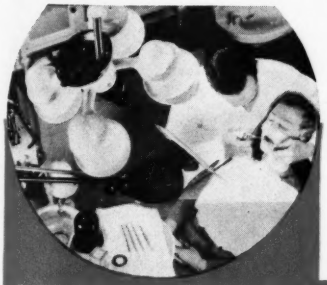
Ritter "Balanced Illumination"... the Ritter Four Cluster Light used with the Ritter Dualite . . . assures glareless illumination with complete freedom from dense shadows. All useful light rays are effectively employed. Special corrective features and prismatic lenses insure an evenly diffused, blue-white light—the nearest approach to daylight. Banish the danger of eyestrain . . . increase efficiency and income . . . be sure of perfect lighting on the darkest days! Write for details on Ritter "Balanced Illumination." Ritter Dental Manufacturing Co., Ritter Park, Rochester, N. Y.



Ritter Four Cluster Light Bracket Assembly readily adjustable to perfect balance. Gives closest approximation of daylight.



Ritter Dualite, perfect combination diagnostic - operating light, concentrated over effective operating area of 10". Visor eliminates glare — acts as holder for X-ray films.



Exhaustive Sightmeter tests conclusively prove that the quality and quantity of light developed by the Ritter Four Cluster Light and the Ritter Dualite are ample for operatories and ideal for all mouth operations.

SIGHTMETER TEST PROVES EFFECTIVENESS OF RITTER BALANCED ILLUMINATION

Comfortable

ble PATIENTS *of a . .*

THOUGHTFUL DENTIST

The difficulties, the discomforts, of new dentures cannot bother and stress these fortunate patients . . . cannot mar their grateful satisfaction with their dentist's services. Their dentist, with customary forethought, is seen to that.

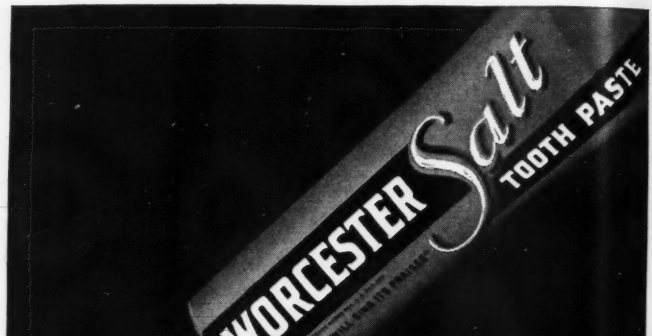
He knows that denture service cannot stop with the making of a denture and seating it in the patient's mouth. Experience and observation have shown him that even the best-made denture is bound to present difficulties at first. Some time must pass, naturally, before a mouth that had been edentulous can be expected to function with a bulk of artificial teeth without a feeling of awkwardness and distinct discomfort. Then, too, the soft tissues, until inured to the new stress, usually suffer irritation. *Getting accustomed to a new denture is thus a trying experience at best!*

So, to shorten it, to make it less trying, he, in common with over 000 other dentists, uses and prescribes DR. WERNET'S Powder for ntures. It forms an elastic, adhesive, and protective cushion between denture and the tissues. It holds the denture, mechanically, more mly in place, and soothes and protects tissues that are tender. By proting comfort and greater assurance, it makes it possible for the denture be worn more regularly, thus hastening its mastery by the patient.

Send for YOUR supply—FREE! Simply mail the lower portion of this ge with your card or letterhead. You'll receive also a supply of ERNET'S Dentu-Creme, the safest cleanser for dentures.—WERNET NTAL MFG. CO., 882 Third Ave., Brooklyn, N. Y.

DR. WERNET'S POWDER

rescribe It with Every Denture You Make!



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Worcester Salt Toothpaste offers you the ideal way to introduce salt to your patients in an effective and pleasant form for oral hygiene. The base of this paste is specially powdered pure Worcester Salt, smooth as silk—plus antacids, and a small amount of pure soap in a delightfully flavored base. It removes soft mucin deposits; it mildly stimulates the gum tissue, and has a delightfully refreshing after taste. When requesting samples please use your professional letter-head. Worcester Salt Co., *America's oldest refiners of pure salt,* 40 Worth Street, New York, U. S. A.

WORCESTER *Salt* TOOTHPASTE

cite the many cases of mottled enamel among school children as good and sufficient reason why the present water supply should be condemned. The Chetopa school board has recently considered a project to install large tanks to be filled with rain water to supply drinking water for school children. So far no definite action has been taken on this proposal.

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INDIANA DEMANDS TWO YEARS' DENTAL WORK

Beginning September, 1937, an additional year of predental training will be required of students at the Indiana University School of Dentistry. This will correspond with the present requirement for two years' of premedical work at the Indiana University School of Medicine.

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ANALYZES DENTITION OF PECOS INDIANS

An investigation just completed by Doctor Truman Nelson of the Harvard Dental School, Cambridge, Massachusetts, has brought out some interesting facts about the dentition of the Pecos Indians, a prehistoric tribe that inhabited the pueblo of Pecos in New Mexico from about 1100 to 1830 A. D.

These Indians Doctor Nelson found, on examining a number of their skulls, had teeth more like those of anthropoid apes than do members of the modern white race. This he deduced from his study of the groove pattern of the lower molar teeth. Irregular or crooked teeth were not common in the Pecos skulls, but there was much evidence to indicate that these Indians were susceptible to other dental disorders prevalent today, Doctor Nelson reported.

Dental caries, for instance, was common but fewer teeth were involved than is the case among civilized people. This primitive tribe also suffered from pyorrhea. Further, the investigation showed that, judging from the actual size of the teeth, the Pecos Indians assume an approximately intermediate position among the races of man. The teeth of these Indians are somewhat smaller than those of Australian and African colored races, but are larger than the teeth of the bushmen and those of members of the modern white race.

In general, Doctor Nelson found that the crowns of the Pecos teeth are relatively large, while the roots are smaller than those supporting the teeth of other racial types. Doctor Nelson's investigations tended to support the current belief that colored, Mongoloid, and white elements have all contributed to the racial makeup of the American Indian.

LAFFODONTIA

Swell Souse: "Where was I last night, Thompson?"

Valet: "I couldn't say, sir, but the bank cashier just called up on the phone to ask if it's all right to pay out a check you've written on your dress collar."

Proud Mother: "Yes, he's a year old now, and he's been walking since he was eight months old."

Bored Visitor: "Really? He must be awfully tired."

And then there was the little girl who signed her arithmetic paper "Mae West" because she done 'em wrong.

Woman: "Hubby, I can hear a mouse!"

Hubby: "Well?"

Woman: "I can hear it squeaking."

Hubby: "Do you expect me to get up and oil it?"

Judge: "So your name is Mullins?"

Witness: "Yes."

Judge: "And you want it changed to Pullman? Tell me, why you want it changed?"

Witness: "Well, to tell you the truth, Judge, it was my wife's idea. She thinks we ought to have the same name that's on our spoons, forks, knives, and towels."

Perkinson: "Did you hear about Willard Elkins, the bank cashier, stealing $50,000 and running away with his best friend's wife?"

Simpson: "Good heavens, who will teach his Sunday school class tomorrow?"

Old-Friend-of-the-Family (to student just returned from college): "I suppose all this talk about present-day college man's life being all wine, women and song is exaggerated."

Student: "It certainly is; you very seldom hear singing in the dorms."

"But how did the police spot you in your woman's disguise?"

"I passed a milliner's shop without looking in at the window."

Now dear old ladies are shocked to see girls do the things they vainly longed to do at that age!

Customer: "The sausages you sent to me were meat at one end and bread crumbs at the other."

Butcher: "Quite so, madam. In these hard times it is very difficult to make both ends meat."

"See here, Tommy," said the teacher, "you mustn't say, 'I ain't going.' You must say, 'I am not going'; 'he is not going'; 'they are not going'; 'we are not going'."

"Gee," replied Tommy, "ain't nobody going?"

SPYCO No. 10

AT $1.40 PER DWT.

REAL SERVICE AND SATISFACTION FOR YOUR PATIENT AT MODERATE COST

A Hard, Gold Colored Alloy (a shade lighter than Tinker No. 2).

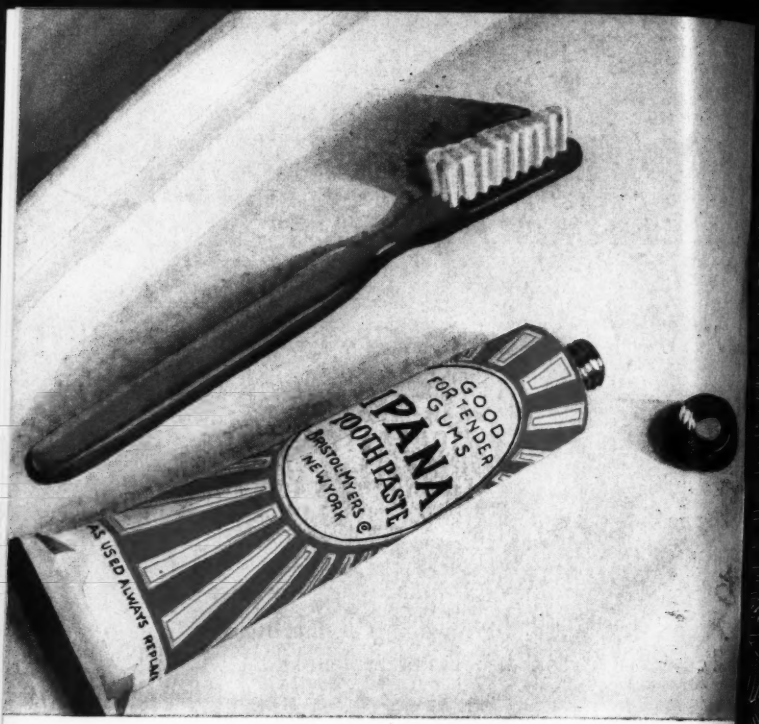
Strong and Resilient, light in weight, and resistant to all corrosive influences in the normal mouth.

It is easy to cast and finish—a thorough discing or polishing to develop the full yellow color of the alloy often being all that is necessary after the casting is complete.

Use SPYCO No. 10 in Saddles, Clasps, Bars and all types of Partials and also in Thin ¾s and Abutments when margins are not to be burnished.

Order SPYCO GOLDS from your Dealer.

Specify SPYCO No. 10 to your laboratory for your next partial.



DENTISTS pioneered— IPANA popularized— the Theory of GUM MASSAGE

DENTISTS made one of their greatest contributions to the health of the world by discovering the efficacy of gum massage in strengthening gingival tissue and building resistance to infection.

And for 15 years Ipana has helped the profession spread the gospel of gum massage through its extensive advertising. Today, gum massage is a national habit in millions of American homes.

Ipana's formula makes it an ideal agent in the practice of gum massage. And thousands of dentists are recommending its use to their patients for the home care of the teeth and gums as an adjunct to their professional work at the chair.

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